The Massachusetts Department of Mental Health

MULTI-CULTURAL ADVISORY COMMITTEE

FIRST ANNUAL SYMPOSIUM FOR MENTAL HEALTH

PROFESSIONALS OF COLOR

March 31, 1993
McLean Hospital

PROCEEDINGS PAPERS

Dr. Chester Pierce, Harvard University
Keynote Speaker

Eileen Elias, Commissioner
Massachusetts Department of Mental Health

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FIRST ANNUAL SYMPOSIUM FOR
MENTAL HEALTH PROFESSIONALS OF COLOR

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WELCOME

Floyd Hardwick
Symposium Co-Chairperson

In working over these past months towards this symposium, what has impressed me the most has been how the many small contributions, just a little bit by each one of us involved with the Multi-Cultural Advisory Committee, has resulted in this tremendous success. On behalf of Marlene, I want to thank every member of our committee as well as every one of you who has come here today to make a presentation and to participate with us in our symposium. The other really tremendous thing about this symposium is that it is a celebration of all the work that many mental health professionals of color are doing throughout the Commonwealth. Today is a celebration of that work, a confirmation of that work. We hope that this symposium, and the work that we do going on from this symposium, will bring to light the contributions that mental health professionals of color are making to our patients. That's really what this is today. I hope that each one of you will go into your different workgroups with that idea in mind. This is truly a celebration of the work and the contribution that each one of you is making, sometimes in very, very challenging situations, sometimes through bitter experiences, but always, always finally with a real sense of victory and a real sense of accomplishment. We are coming together to celebrate you and your contributions, and with that in mind, I want to thank you.

I'm going to make an announcement that may be a surprise to only one person. What can I say, in another time, in another place, we might have called her by a different name, we might have given her another title. But today, in this time and in this place, we call her Marlene Tarpley. We on the committee want to give to Marlene this plaque. There is one interesting thing concerning working with Marlene that I was thinking about this morning, as I was coming in; it's that Marlene has really demonstrated for me how one, through the long haul of a complex and difficult task, balances possibility and necessity. Now, what do I mean? What I really mean by that is that Marlene had this special way of supporting you and encouraging you and making you feel like you could get through it, but before she hung up, she always gave you just a bit more work to do. And I think that's the bringing together of those two things, possibility and necessity, the dream and the reality. I just admire that so much. So, we want to present Marlene with this plaque from the group. The plaque says, "This plaque is presented with love and respect to Marlene Tarpley, Chairperson of the Multi-Cultural Advisory Committee for the State of Massachusetts, Department of Mental Health. Beautiful souls like you keep hope alive. From all the members of the Multi-Cultural Advisory Committee, March 31, 1993."

INTRODUCTION

Eileen Elias, Commissioner
Department of Mental Health

Good Morning! What a wonderful way to start this important day. Last evening I had the honor of attending, for the first time, a Black seder. A seder commemorates the Jewish slaves leaving Egypt. It symbolizes that which both Jews and people of color have experienced, at one point in time: discrimination and the taking away of freedom. What was most important for me in that experience was hearing Hebrew sung by the whole community. It was a wonderful, moving experience of partnership. And, partnership is what we are talking about in the kind words that Marlene gave in introducing me. There is no way that this Department of Mental Health can move forward in its restructuring effort without partnership and without an inclusive participatory process. You are all key to that endeavor. This partnership is an educational process for all of us. The reason it was so important for me to ensure that the multi-cultural committee went forth was to assure attention to our consumers from various cultural and linguistic backgrounds. We are helping to manage the issue of mental illness, but we're not treating the issues of mental illness. And the only way one can offer proper treatment is to understand the whole person. Therefore, what all of you have been doing, the whole committee process that has led to today's event, assessing the system, understanding and providing data, developing amongst yourselves a strong statewide peer support group is not just to meet Federal regulation, but rather it's being done because this is right, it has to be done.

What's unique about this meeting occurring today, and what it will lead to, is that this week is the anniversary of Martin Luther King's death. His death is reflective of the movement that he inspired and this process is a part of that. The Department's whole restructuring effort, Public Managed Care, is based upon the Comprehensive Community Support System (CCSS). I am looking forward to receiving the papers from today's symposium which focus on the major areas of our CCSS and seeing how you view the CCSS through your own unique experiences and perceptions, both personally and professionally. Today is not just a one shot event either. What Marlene has done, with the committee, has ensured that this is the begin of the begun and that this will lead to a conference. And that conference will be an example again of an educational, participatory, inclusive process that will involve invitees to share the findings from today's symposium across all cultural experiences, White, Black, Chinese, Hispanic, etc., all that need to come together and learn again from what you pull together out of this symposium. In summary, I am honored. Thank you. Good Work. You are part of a catalyst of change.

I have the honor of introducing Dr. Chester Pierce. When Marlene first learned that Dr. Pierce would, in fact, be the keynote speaker for today, her excitement was unbelievable. Clearly, a real queue. So, with that, Dr. Pierce if you could come forward, I thank you. I understand, that as a Professor of Psychiatry at Mass. General Hospital and at Harvard Medical School, you provide a role model to both the staff here and to those individuals who are coming up through the educational process. You are also a Professor of Education at Harvard and a Professor at the Harvard School of Public Health. The numerous leadership positions that you have held, especially nationally, is also something that everybody should recognize. You were part of the founding National Chair of the Black Psychiatrists of America in 1969. You have held several editorial board appointments with national publications of psychiatry, clinical psychology, as well as educational and interestingly, sports medicine. Truly, a wonderful array. You have received many national honors, national advisory positions and national and international consultantships. You have written over one hundred and eighty books, articles, textbooks, chapters, special reports, and reviews. I am honored and I thank you.

KEYNOTE ADDRESS

Dr. Chester Pierce

I thank Commissioner Elias, but Marlene made only one mistake; she didn't tell me how long to talk. That could be dangerous, so I'll have to try to be mercifully brief and curb myself, because I really am delighted and overwhelmed to be here.

We are all limited to our fraction of truth. Thus, we all perceive things from that fraction of truth.   I was thinking this morning that it has been about fifty years since I first came to this hospital when I was a college student.   I would never in my life have dreamed that I would ever live to see a meeting like this at this hospital. Now, it's also been forty years since I've been teaching in medical schools; the only thing I've ever done with my life has been a teacher in medical schools. I've been teaching for forty years and I never would have thought there would be a gathering like this when I first started to teach. And so, I am delighted this initiative has been established and as I look briefly through some of the abstracts, I think they're wonderful and that we're on the right road. So this morning, trying to be mercifully brief, I will only cover a few things and I will start with history because that's when you come into the movie. Much depends on how you think it will end up, and I came into the movie probably a bit earlier than most of you, probably everybody here, and I think it's important to get some continuity of when you came into the movie.   Then I will give a few brief ideas about my own views about the topic you're undertaking, and mention some analogous ways to think about it, and finally just mention some of the thrusts I think should be the mission of public mental health.

Now historically, when I came into the movie and sat down in it, of course it would have been rash for anybody to think you could become tenured by talking about race issues, so obviously I didn't write about those things.   I did write in the fifties and sixties and so on, but that wasn't the way to get tenured. You couldn't, in fact; in all honesty, I'm not sure it's the way to get tenured today. I don't think I would advise David Henderson to spend his life doing a lot of this to get tenure. On the other hand, he has to do it because he was born into it. But, that means part of our being is we have to, you have to work and do more work, and be scattered and fractionated. When I entered psychiatry in the forties and the fifties, I literally only knew one other Black psychiatrist, and she was my teacher here at Harvard. I didn't know anybody else. I didn't think I could earn my living as a psychiatrist. At that time, there could be no research about the kind of matters you are talking about today.

Gradually, more people came into the field.   There still couldn't be any research because people were busy taking care of things and so on. You have to have a sample size big enough of people doing clinical work before some will be able

to do research. But there began to be calls for more research. After more people entered the field, there began to be calls for some kind of ethnic specific kinds of research. And yet, at this point, it still had not become established. However, in all fairness, this was partially due to the small number of researchers involved in this area. When professionals of color became better represented in the field and in academic settings, they still couldn't do enough research, because that wasn't the route to tenure. Today, given the many demographic concerns, there is fledging acknowledgement that we have to do the kind of research that we are attending to today and this is a splendid start. We do need to find out, in fact, are there ethnic specific kinds of treatments and management of patients? If there are, how do you do them, and how do you keep up with them and so on? One of the problems has always been that the Whites have been the gatekeepers of what should be studied, because they control the money and they control the institutions. Furthermore, if they were well intended, they could only teach what they knew. And, from their perspective, their fractured truth, that is all they could teach. But now we have more people who can teach other things and offer other perspectives. We also have more people who can do the kinds of research that we need so that historically, we are getting to a point where we now cannot shirk the responsibility of doing this important research.

Now, some would argue that because people of color do research, it would be better. But certainly, I think it almost surely would be different. And that is what you have to do. And that is what I want to try to underline today. You should unfetter yourselves and let your mind soar and do not be too much into traditional kinds of thinking about what kind of research you should do because that's been the trouble all along. The people who have been in the field have also been taught by the Whites. They have tended to do the same kind of research. Then you can get it published because then it's permissible to the editors, and you perpetuate what they want. Also, if you're getting their money, you have to say and do what they think is to be done. These are all significant problems limiting how we can get the research done.

The critical issue, in my view, is to study racism. That seems to me very obvious. But it's not at all obvious to White gatekeepers, editors, and research fund disposers, and to clinical directors, and people like that. You have to study racism. I think it also requires a certain kind of study. I think the best kind of study would be to study White folks and often to study them unbeknown to themselves. Now you laugh, but I'm serious because you see, we're the target subjects and in the course we're always the target subject when they do things. Do you realize that in the fifties, people would argue whether or not a Black could be analyzed, in the psychiatric literature? This is where the thoughts were when I came into the movie. And so, people of color have collected a lot of information about Whites informally, over the hundreds of years that we've been here, but it hasn't been systematized. It has not been managed and directed to be of use. Thus, one test would be to systematize the wealth of material we have. There have probably been few White men who have worked in Black homes. On the other hand, I have

worked in White homes. So I have some systematic information from being a domestic that Whites don't have. First, they act differently. One must be able to study them without their knowing because if they know you are studying them, they will act differently like any group does. This presents a big problem.

There are lots of ways you can study White people without them knowing it. However, rather than tell you how to go about this specifically, it is best for you to think of your own ways. This is a necessary step if you go to ask for a grant. For instance, I might decide to pursue a grant to study racism. In particular, I may decide that I would like to explore how mothers become racist and give it to their children, White mothers. Therefore, I want to study little White girls. Now, if I went to ask for a grant for this, almost surely a research board would deny me the money. They would find all kinds of reasons: wasn't scientific, wasn't this, wasn't that, so that I would not receive funding to study little White girls. However, a White man can say he wants to go study violence in the Black community and that he wants to study the Black girls. They will say, that's a very good thing. So he can go study. I think that you have to have a critical understanding of how money is dispensed.

The definition of racism is one in which people take prerogatives they wouldn't take with their own kind because of their ideas about the value, the superiority of skin color. Always in that kind of view, White is superior. In our society, the more colored you are, the more you will, and can be, discriminated against. It's such an overwhelming phenomenon that it is predictable with a degree of fidelity that physicists would enjoy. And yet, we do not study and quantify it like that. The factors that keep people enslaved and enthralled by racism are having their space, their time, their energy and mobility curbed and inhibited. The amount of racist manifestations is defined by their space, time, energy and mobility. This is true whether you look at individual racists, an individual race, or a whole community.

I think that it is important not to think in the vocabulary of your oppressor. If you are being taught by even well-intended Whites, they can only teach you what they know. I remember once I had the great honor of presenting a case to Dr. Michael Balant, a famous, internationally famous psychoanalyst. Doctor Balant and two famous, internationally famous Americans like Balant, listened to me present. They thought that the important thing about this case I was presenting of a Black lady was what happened to her when she was four years old down in Alabama. Yet, somehow I knew this was not quite right. I thought that what was important was what she was telling me. She told me that she lived in the middle of a big city, at that time in the fifties, and had to walk down four flights of stairs to go to the bathroom outdoors. From where she sat in the outhouse, the door was kind of crooked, so she could look through where the door was crooked and see a sign saying only $5.00 for a steak dinner in the Nellen Plaza Hotel. Now, she was as far away from that $5.00 as she was from the moon. But you see, the professors didn't talk about that. Now I'm not criticizing, but they just didn't understand what I thought was important. They wanted me to find out how she was treated at age

four when she was down in Alabama. That was a difference of perception. Almost always in Non-White and White interactions, there are these perceptual distortions between what one group thinks is true and the other group thinks is true. Not that there is any effort to be dishonest or distorted, but the perceptions are different. Therefore, you will construct different kinds of research ideas and have different thrusts.

Therefore, you cannot use the same language; you can't read their textbooks and use their words. We have to be very careful about using language. We have to think up our own semantics and initiate, and think up our conceptualizations to speak about and describe things. So, to offer a few conceptual ideas which I think are important, I would start first by listing a thousand words that are commonly used that my colleague, Dr. Profit, and I think are perjorative. When you first go into the field of mental health, you learn a great deal about defense mechanisms. I do not think that defense mechanisms are that important for a person of color. What's important are offense mechanisms, which are visited on them. There are a number of offensive mechanisms. They are offensive in intention, they are offensive in meaning, and they are offensive in who initiates, in who takes the initiative action, and where it goes.

If you are colored, you are in the position of being the defender. One of the objects of racism is to make you think defensively. If you are thinking defensively, you are thinking much more rapidly, and scanning a much wider universe, and making more rapid decisions, and thinking about end points rather than process, so you think differently. This is, of course, one of the things that Whites want you to do, to stay on the defensive. The object of racism is to keep you on the defensive so you can be deterred and so you will be grateful for what you are getting, and you will comply and be deferent. Offensive mechanisms are rampant throughout society. Their major impact is that they leave psycho pollutants. We have a lot of psycho pollutants around, just toxifying us and poisoning us and we have to get rid of them. One of the efforts of your research is to try to reduce these pollutants.

I offer this example of a psycho pollutant. In medicine, there is a concept of trace elements and trace contaminants. A trace element means that you have to have just a little bit of something to live, otherwise you die. For instance, just a little bit of cobalt or just a little bit of manganese is all that is necessary to live. With a trace contaminant, on the other hand, if you get a little bit of it for a long period of time, just a little bit each day, something terrible will eventually happen. For example, if you give a little bit of carbon monoxide every day for eighty days to a cow, for eighty days or ninety days nothing may happen to the cow. However, on day ninety one, the cow aborts. You take that same concept and make it a social trace contaminant or social trace element and you understand the phenomenon of psycho pollutants. A trace element for a White man might be a pollutant and therefore a social contaminant to me. For example, the statue in the Park Plaza and Park Place of Lincoln with the slave that's down on his knees in chains and diaper, and Lincoln has his hand over him, for a White man that's a social trace element.

That makes him feel pretty good. You know, we emancipated the slave, we did this and so forth and Lincoln's given beneficence, holiness, over this slave who's on his knees, in his diapers and chains.

But for me, it's not an element, it's not helping me to live like them. It's another gratuitous reduction making me feel a little bit more defensive, a little bit more deferred, and so on. As an artist, you could make lots of the emancipation images without depicting a group so negatively like that. That is offensive to us. This is an offensive mechanism, a very common offensive mechanism of micro aggressions because most racism is not gross and large. There are of course the incidents which most people read about and hear about all the time because of the White media, about people being beat over the head or hung and things of this sort. But for most people, the everyday subtle kind of racism is non-verbal and usually kinetic in terms of small, subtle, innocuous conscious and pre-conscious put-downs. For example, someone may throw you back the change after you pay for something. These are the little micro aggressions that build up and accumulate. It is the cumulative aspect of them which depreciates and causes stress and probably enters into our earlier demise and increased morbidity. Those kinds of things are researchable. Of course you can also start with the quantification, making out the formulae about space, time, age, and mobility and determine if this is true or not.

There are a number of analogous ways to think about racism and I have studied White folks unbeknown to themselves from lots of ways. The micro aggressions, for instance, I studied while I was acting as Assistant Football Coach for the Harvard freshman football team. At the time, the question was, how do you make people deliberately offensive? Because that's what Whites do, they have to make their children deliberately offensive. I wanted to know how that happens. How do you go about making people good offensive agents? One could say I was out there coaching the football team, but I was really studying how the White folks make people offensive. We have crucial questions to ask. For instance, how is it that Whites can raise generation after generation so the people will expect that they're entitled to be offensive to other people and that it is critical and important to their democracy to degrade and demean other people? These are researchable questions and these are kinds of issues which I think are much more pertinent than many of the studies which you see in traditional journals.

However, you have to study a lot of things analogously, and you have to study them indirectly. I studied White male behavior at the geographic South Pole. You see, I could study what White folks do under conditions of extreme stress because they could use this research to keep people from feeling great stress at the geographic South Pole. But, the stress of a person living in the ghetto, they don't do anything about. The fact is, if they wanted to, they could take the same principles and apply them and get rid of stress in the ghetto. In my view, it's much more difficult to be a child in the ghetto than it is to go to space.

I have worked with the astronauts and I'm studying White folks to see how it is that they are able to adapt in this environment. There are lots of ways you can study people for your purpose without letting them see this as a deliberate kind of undertaking. You can use lots of analogies. Other analogies which I have found useful, for instance, are from studying animals. I have studied whales and elephants and penguins and all manner of animals, particularly animals in captivity, because that's what we're in, aren't we? We're in a captive situation. That's what confines your space, time, mobility and energy. If you're an elephant in a pen, you're victimized the same way as if you're Black in a ghetto, in terms of where you can go, who's gonna herd you, ride herd, and so forth. Philosophically, you're trying to answer the question about what makes us human as compared to animals and how do we appeal to that part of us? That is the reason why Blacks can treat Whites, and Whites can treat Blacks in certain ways, because they are appealing to human sentiments. Manipulation and maneuvering of these human sentiments defines good management. But, you have to first know what is specific about being a human being if anything? What's good and bad or indifferent? If you are a member of the whale-elephant society, reporting about human beings, what would you say about them? What kind of creatures are they?

Now, I think there are many other analogies that you could talk about. The one that I have done lots of thinking about over the years is the fact that we should all be experts in terror and torture because the definition of racism is congruent with the definitions of both terror and torture. And in fact, terror, torture and racism are congruent or identical, and they might be supplementary or complimentary or synergistic as they inform one another. And so, if the purpose of terror is to get your attention, that's what racism is about. If torture is to inflict physical and mental suffering to make you inform or conform or confess, that's what racism is about. So what we really need to do is to think analogously and learn a great deal about torture. We know a great deal from the literature about who becomes torturers and how you make people torturers, which is the same thing that the general White population does. You don't take deranged people to try to make them torturers. You take a regular, everyday kind of person to make him a torturer. That's what the object is, so we should be looking at this kind of literature and see what we can get from it. We also can learn who does well in these situations, the same as who does well in a disaster. Generally, our lives are more often compared to Whites who are less likely to have disasters. There are a lot of things that we can distill out immediately, about who does well and where the strengths are, about how you deflect the things about being terrorized or tortured.

Because I'm trying to be mercifully brief, I will end with just a few things. I often hear that professors, particularly those getting to be senior citizens, like to pontificate so I have to curb myself. I don't want to talk too much, but I think there are some missions in public health and public mental health that you might consider in your deliberations as you proceed. First of all, I should indicate that my view is that racism is a public health illness. It is a public health illness because it is delusional. Even with presentation and confrontation of facts, people can still

continue with the false belief that something is not true. So that makes it an illness. Now it's a public health illness because public health illness is one that affects masses of people. Since everybody in the United States is affected, that's mass illness. It's a public health illness when you can't treat it one to one. You can't treat smallpox one to one, you have to get rid of smallpox in twenty-one countries at the same time. You have to make a massive kind of effort. It is also a public health illness because it requires a great amount of money to get rid of it. If you're going to treat twenty-one countries, that's a massive mobilization. You have to think about housing, jobs, and all kinds of things to attack a public health illness. And also it's a public health illness because it leaves tragedy. If we all had smallpox tonight, and then those of us who survived, in twenty years from now (not me, but some of you would be here twenty years from now), after survival, some of you would have heart disease, some of you would have lost digits, some of you would have neuritis, etc.

I think a mission for public health and public mental health, the Department of Mental Health, would be to try to focus like that. I think the chief focus should be on children. All the colored minorities are younger than the White population. That, in itself, is enough reason to do it, but there are other reasons to focus on children. I think of the kinds of things we need to focus upon, in looking at the public health model. First of all, every child should become expert in propaganda analysis and media consumption. This is important for the child to understand. What are the factors that want him to have lower self esteem, to have lower confidence? Whether he's reading the comic strip or a newspaper, or magazine, or looking at a mural, or looking at TV, or listening to the radio, or to people talking around him, he has to be able to understand quickly that this is propaganda and that he does not have to absorb this. I can cut through this and I can understand this. That's a psycho educational public health problem.

We also have to promote pro-intellectualism as a group. The Asian group does not need as much help in this area, but Blacks, Hispanics, and Native Americans need a lot of help to understand that in order to have an aim, and have hope, you have to cherish and seek pro-intellectual kinds of things. The most fundamental factor for children in this area is to be sure they read. If they do not read by fourth grade, then they're in trouble. There are theorists who say that is what starts people onto the road to violence. Actually, I shouldn't say violence, I should say counter violence, so as not to get into using the White folks' vocabulary. They would have us to believe we're the violent people. We are not, we are doing counter violence. Violence has been witnessed by us over the hundreds of years that we have been abused. Thus, we have to do everything we can to promote pro-intellectualism.

Finally, I think you have to focus on studying group dynamics. I don't mean just simple group dynamics like treating people, etc., we have to rapidly progress to much more sophisticated kinds of studies to understand inter-group reactions. What happens when Hispanics and Asians are interacting? What happens when

Whites and Native Americans are interacting? These are all things you can study, and learn about. But also, you can begin to teach in terms of public health kinds of issues how to prevent and dilute things. It is not just simple therapies. For instance, by the time a child is in the first year of high school, s/he can be quite sophisticated about such matters as contingency management, time management, leaderless groups, counter contingency management, decision making, defusing situations, and conflict resolutions. This requires a different kind of sophistication and more than just studying a simple little group.

My charge to you then is to do all these things and I would leave you with this thought. Even though I have been talking more about the psycho-social aspects, we have a heavy burden, a great obligation, and a tremendous challenge to integrate this with lots of biological things. We can not let our political or philosophical views interfere with such investigations. I am very glad on the one hand and very sad on the other that there seem to be less people going into psychiatry, particularly Blacks, and other minority groups. But, on the other hand I'm glad because they're going into molecular chemistry or molecular biology and things of this sort. We need people like that one who can read and understand the literature to combat the kinds of possible political usage such information could be put to, and also to initiate studies and integrate them with people who do psycho-social studies. We must be balanced as we think about these research issues.

Marlene L. Tarpley, Chairperson
Multi-Cultural Advisory Committee
Position Paper

INTRODUCTION

CULTURE

The people of the world are not homogeneous. There does not exist any one group of people that is homogeneous. Our universal homogeneity is rooted in the fact that all human beings have basic needs: food; shelter; self actualization; love; knowledge; etc. These needs are manifested in similar ways. However, given the environment, the circumstances of our existence, the sum of the tools available to people to fulfill these needs, the methodologies utilized are modified. Thus, cultures and sub-cultures evolve.

Culture, then, is the variation on a standard theme, the theme being life, liberty, and the pursuit of happiness. Culture is the aggregate of ways in which groups of people use and transmit the use of the tools available to them.

Operating Principles:

o   All individuals are human beings.
o   All human beings share the same basic needs.
o   The uniqueness of our existence is dependent upon the tools we have to shape our lives.
o   Tools consist of our physical environment, economic status, sociological factors, education and information, and psychological milieu.

People of color in America are fashioned into groupings that are not analogous to their cultural framework, such as African Americans, Asians, Hispanics. Each of these groupings contain significant cultures and sub-cultures. Asians, for example, are Chinese, Japanese, Cambodians, etc. Within each of these cultures there are additional sub-cultures. Chinese from different localities in China had different tools available to them, hence differences in their culture. This is true for all groups in their countries of origin: Africans, South Americans, Spaniards, Indians, etc.

Oppression and racism are also variables which have impacted the culture of people of color, depending upon the extent of infiltration, colonization, missionary activity, media, education and information.

Caucasian Americans are also fashioned into a group that is not analogous to their diverse cultural heritage. Caucasian Americans are Italians, Irish, English, Jewish, Spanish, etc. Each of these groups, in their country of origin, represent unique cultures and sub-cultures. However, in America, these Caucasian groups have been fused and one culture, the culture of Whiteness, has emerged. America has intervened to modify the perception of the culture of these distinct groups by making similar tools available to them and through education and information sharing, either designated the uniform use of these tools, or incorporated enough diversity in the use of tools to include the ways of each of these sub-cultures.

American culture is eclectic, comprised as it is of behavioral patterns, arts, beliefs, institutions, and other products and thought characteristic of the Western world.

This potpourri of Caucasian intellectual, social, and artistic activity has been developed and marketed through formal education and the media. It embraces just enough of each Caucasian ethnic group or sub-culture to create the perception of inclusion and homogeneity. It creates, through inclusion and education, a consensus broad enough to position it as the dominant, hence superior, culture.

White children who enter school find themselves in the text as part of the American culture. This is reinforced in every aspect of American life. All American institutions, media, classical music, art, dance and literature, adults' and children's games, game shows, movies, food, perpetuate the myth of a common culture for White people. Caucasians respect their whiteness. They accommodate their differences with built in supports and diffuse their diversity through information sharing.

Oppression and racism have had a significant impact upon Caucasians, as well. For, as the deliverers of oppression and racism, Caucasians have to perpetuate the notion of superiority in every aspect of their existence. This can be seen in the false historical accounts that are currently being unveiled; in the media, as criminal acts of Whites are rationalized, justified, dismissed as anomalies and people of color depicted as irrational and animalistic; and in daily occurrences which place no value on the lives of people of color. It may also be a factor of the therapeutic milieu which encompasses theories based in stereotypes and racism and practitioners trained in these theories. Hence the acts of sustained oppression and the maintenance of racism by White people results in dysfunctional behavior and attitudes which permeate their society and affect their psychic reality, as well.

People of color do not have a culture of color to mobilize and nurture them. They are fragmented by the variations which they formulated to create a culture, by the adaptations which they have made to accommodate oppression and racism, and by the humiliation they face in the inferior status which they have been accorded, and, in many cases, accepted.

People of color who come to this country must accept the dominant culture and adopt its way of using the tools that exist in order to satisfy their basic needs. This, in itself, is reasonable. However, the tools are not always accessible to them, and there is always some doubt about the ability or authenticity of the use of these tools by people of color. Hence, people of color are expected to be acculturated but are never completely assimilated. Further, since ownership is assumed by the "Dominant Culture," the possibility of separate and equal cultures of color does not exist.

Operating Principles:

o   People of color are given artificial classifications that underestimate the diverse cultures and sub-cultures which exist within these grouping (e.g., Asians = Chinese, Japanese, Cambodians, etc.).

o   Caucasians in America have formed an eclectic culture of whiteness which ignores the diverse cultures and sub-cultures which exist within this group.

o   A culture of color does not exist. People of color have a dual struggle: (1) the separation of their identity from the imposed grouping (e.g., Chinese from Asian, etc.) and (2) the need to identify as closely as possible with the "Dominant" culture.

o   Caucasians, primarily those who identify with the Western world, are all a part of the culture of whiteness. White people have a dual struggle: (1) the maintenance of the facade of superiority, and (2) the enforcement of oppression and racism.

o   The struggles of each group creates a dysfunctional state for both.

o   Successful psychotherapy is impeded by all of these struggles.

LANGUAGE

Language is the documentation of basic human needs, the tools that are available and how these tools are used to satisfy those needs. Language is the vehicle used to transmit this information to everyone within the group. It is specific to that group and the group's experience. It is a documentation of the culture. As such, language is not, cannot be, separate from culture.

Association of Language with the Operating Principles:

o   All human beings have the facility for language.

o   The language they learn to speak reflects basic human needs and the use of the tools available to them to fulfill these needs.

o   Language is specific to each group, each sub-culture, because the tools available and the use varies. A group of Chinese in one locality in China may speak differently from a group of Chinese in another part of China because the tools available to that group and how they may be used are different from the tools available to the other group and how they may be used. Hence, once in America, it must be realized that not all Chinese, much less all Asians, have the same language. This is true of Africans, Japanese and any other group, as well as African Americans and Spanish speaking people born in various locations in America.

o   American English is derived from the "King's English." It, too, is the documentation of the tools available to Americans. It reflects and documents the culture of whiteness. American English, like the culture, encompasses differences. It educates, informs and reinforces the inclusion of these accepted differences through various mechanisms (e.g., regularly updated and revised dictionary and educational curriculum; media; games; etc.) American English includes vernacular and dialects, various religious terminology, words and phrases from the French and other Western countries and cultures, as well as derivatives of words from Western languages.

o   American English and Culture is taught in every school system in the United States (and in many systems throughout the Western world.) Languages and the culture of people of color are the exception when taught in schools.

o   Language and its cultural implications is one barrier to acculturation and assimilation for people of color in American culture. However, the primary barrier is the unwillingness by all, to expand the definition of American Culture to include people of color and to actualize the original ownership of America which is inclusive of people of color.

o   American English, as a vehicle to maintain the superior status of Whites, incorporates offensive, stereotypical and racist language which is taught and reinforced in every medium. Conversely, defensive language is just as widespread.

o   Knowledge of the language and culture of people of color is necessary for appropriate diagnosis and treatment by mental health workers.

o   Clinicians must identify language which documents basic human needs of the consumer and seek clues to what tools were available and how they were used. Stereotypes and racism, as well as the struggle to negate one's own language and culture, impede the effectiveness of the clinician in this process.

o   Language and its culture along with the acceptance of White superiority prohibit the formation of a culture of color. It also serves as a means to

fragment the family. Young children who come to this country with their families learn American English. They become acculturated more readily than their parents and elders and strive to assimilate. The natural stages of peer prominence and adolescent independence are exacerbated by the language and cultural differences experienced within the family. Parents are further alienated from the child by American institutions which flaunt the independence of children at such young ages which may be different in other cultures. (NOTE: This so-called independence of young White children is perceptual. Because the institutions are White through the interconnectiveness of Whites in various positions, a White child who appears to be independent may be mentored and supported behind the scenes by a teacher, a tutor, a call here and there.)

SUMMARY

People bond through similarities not differences. The old adage of America being a melting pot was facilitated by the creation of a culture which provided the same tools to all of the various Caucasian groups which came to America and disseminated uniform information and/or information which included variations specific to those groups on the use of the tools. Oppression and racism were factored in immediately with the exclusion of Native Americans, slaves, etc. and the assumption of ownership by White Americans.

The demographics of Massachusetts have changed dramatically in the last ten years. People of color, reflecting a multiplicity of languages and cultures, reside throughout the state. Data indicating population shifts document a diminishing White population and a significant increase in people of color. The percentage of change in groups of color in various cities within the Commonwealth has been as much as 200%.

These statistics call into question the economic, political and philosophical reality of doing business as usual. How much longer can we continue to exclude language and culture from what is now perceived as a mainstream therapeutic environment? What is the short term - long term need? What functions - research, services, human resources, community - are in place that can be utilized immediately? What has to be developed - policy and practice - to satisfy long term needs? How do mental health administrators, professionals, consumers, and family members establish a flexible timetable, objectives and methodology to incorporate appropriate service to people of color based upon the need and desire to serve?

Certainly, the dangers of inappropriate service - misdiagnosis, ineffective and costly treatment - are apparent. Thus, a decision has to be made before any of the above mentioned questions are answered: <u>Do Mental Health Administrators and Professionals Intend to Serve People of Color and What is the Scope of Services</u>?

o   If the answer is <u>NO</u>, then monies should be made available to redirect people of color and no pretense of service should be made. Families and community will, possibly, continue to facilitate their own and, perhaps, a service network will evolve. Or, they will protest.

o   If the answer is <u>Yes, but a limited scope</u>, then parameters should be defined, made known, and culturally appropriate services made available within those limitations.

o   If the answer is an <u>Unequivocal Yes</u>, then the need must be ascertained, the necessary tools incorporated, and education regarding the use of all tools given to everyone.

If the answer is yes, unequivocally, in order to begin the process of inclusion we must begin to bond. As previously suggested, there are several elements, when accepted, which simplify this process:

1.   All individuals are Human Beings.
2.   All human beings have the <u>same</u> basic needs.
3.   These needs are expressed in a language which reflects the tools available and their use.
4.   Every individual is unique and accommodations are made for each that eventually become systematized, when accepted.

Once the economic and political decision is made to include the culture and language of people of color into the definition of American culture then all people must be educated and informed about the other. When this occurs successfully, threads of similarity and commonalities of the human experience will be evidenced.

SYMPOSIUM OF MENTAL HEALTH PROFESSIONALS OF COLOR

The March 31, 1993, Symposium amassed the research, clinical and practical knowledge of those persons who reflect the cultural and linguistic groups served by the Department of Mental Health. The conference was limited only by space. Over one hundred & fifty (150) professionals, consumers and family members gathered to share their expertise in the areas of Mental Health Services (inpatient, case management, etc.), Rehabilitation, Family Support and the use of Significant Others, Human Resources and Providers. Discussions focused upon adults, as well as the elderly, children, adolescents and the homeless.

The proceeding papers document the keynote address, submissions, participants and this position paper which is a consensus of the symposium's deliberations and recommendations.

RECOMMENDATIONS:

Administration

Recommendation I	**Institutionalize function of the Multi-Cultural Advisory Committee**
Mechanism:	(a) Board with decision-making power, or
	(b) Unit within the Department

Role: Planning, oversight, implementation, budgetary responsibilities/recommendations regarding communities of color

Function:　　**Outreach and Education**

o　　Advise and assist Department staff.

o　　Advise and assist communities of color.

o　　Establish roster of mental health professionals of color and act as a conduit to and for the Department.

o　　Disseminate information to <u>ALL</u> regarding communities of color.

*Newsletter
*Meetings (Department & Community)
*Seminars
*Multi-Cultural Mental Health
　Research & Training Center
*Bulletin, grand rounds and seminars

o   Coordinate Multi-cultural Mental Health Research and Training Center
o   Integrate resources into CCSS process
o   Maintain Multi-Cultural Advisory Committee
o   Assist Area Multi-Cultural committees
o   Coordinate DMH Multi-Cultural Activities with other Federal, State, Local and Community Agencies
o   People of Color - case management - act as a resource for service linkages and conduct ongoing needs assessments.

Short-term Suggested Educational Activity:

Establish one to four Multidisciplinary Multi-cultural Treatment Team(s) to hold Grand Rounds on suggested cases with specific cultural and/or linguistic characteristics once each month at four (4) locations throughout the state which would be open to all DMH staff and providers.

o   One team could be based at the Multi-Cultural Mental Health Research and Training Center and Grand Rounds would be held there. The team could also travel to specific locations throughout the state.

o   A team could be established at four (4) different DMH area locations, and hold Grand Rounds at different times throughout each month for all DMH staff and providers.

Cases would be submitted by each DMH facility and provider agency and would be accepted based upon their educational value. This serves as a vehicle to educate staff and assist them in serving people from various cultural and linguistic groups. Transcripts of the cases could be distributed through the newsletter. Family members and consumers should be an integral part of this activity. Team members would be drawn from the Multi-cultural Advisory Committee.

CULTURE

Recommendation 2   **Culturally Sensitive Services Have to be an Administrative Priority**

As Dr. Gaw states in his paper, Psychotherapy of Asian Americans, "each (therapeutic) encounter is cross cultural". An administrative mandate for culturally sensitive services ensures that mechanisms are put in place to facilitate that mandate such as:

o   A clinician's personal view of the client as an individual necessitates the use of common sense and an evaluation of values; seeking clues from consumer and family members; actualizing the stress of adjustment (Tavares), the various stages of acculturation, effects of oppression and racism, and different ethics and value assumptions.

o   Multi-cultural education and research

o   Integration of multi-cultural personnel throughout the system.

Recommendation 3   <u>Expand Communication (Interpreter) Services</u> within the DMH Refugee Assistance Program (RAP) and Office of Multi-Cultural Services (OMCS).

Recommendation 4   <u>Establish a Statewide Resource Bank</u> through the Office of DMH RAP and OMCS which would identify DMH staff and providers with a facility for various languages who would exchange time and expertise.

Recommendation 5   <u>Develop Multi-Cultural Treatment Teams and/or Treatment Teams</u> which include at least one representative from one of the primary cultures of people of color that we serve, to be a resource to the Department. Team must be aware of resources available for all ethnic groups.

<u>RESEARCH & TRAINING</u>

Recommendation 6   <u>Actualize Multi-Cultural Mental Health Research & Training Center</u>

o   Research specific to multi-cultural populations

o   Consultation to Department's research efforts to incorporate multi-cultural perspectives

o   Education and Training - Transfer of research information to DMH staff and providers

o   Credentialling of staff

o   Test and develop different models of therapeutic and theoretical perspectives for multi-cultural populations

o   Development Component - Access monies on National level through Federal and Foundation

Grants for the purposes of research, education and pilot programs.
o Establish linkages with Universities and professional organizations, incorporate Mental Health Professionals of Color.
o Publish Multi-Cultural Mental Health Journal

FAMILY AND SIGNIFICANT OTHERS

The Comprehensive Community Support System assumes the responsibility of the family and significant others as a part of the network of care. This assumption must incorporate the role of the family as the primary caregiver and that of significant others as _essential_ support to the family into the complete continuum of care, in order to provide appropriate services.

Recommendation 7 **Incorporate an on-going program of education and information gathering and sharing into the system**

Education would be provided to mental health professionals regarding various cultures, the role of the family, and the function of significant others and who they are.

Education would also be provided to family members and the community regarding mental health services, access, treatment, medication, etc.

This can be accomplished by existing offices within the Department and by funding the Multi-Cultural Mental Health Research and Training Center. The Center, along with mental health professionals, providers, community members, consumers and family members, would plan and present a yearly agenda of seminars on and off site.

The Multi-Cultural Advisory Committee could gather information specific to each culture regarding the role of family members and the community, identify significant others, and document the use of healers and others who assist the family when a member is mentally ill. The information would be included in the Committee's newsletter and the Center's bulletin.

Orientation of DMH and provider staff should include education and information regarding the use of family and significant others from cultural and linguistic groups

specific to their area. Multi-Cultural Advisory Committee members, community mental health providers and professionals of color could be used as resources.

Educational and informational materials should be available in languages reflecting the culture of the communities served.

Recommendation 8

<u>Family members and significant others should be involved in the entire spectrum of treatment as a natural support. In conjunction with this, the issue of confidentiality must be examined.</u>

The family is the primary caregiver. In most cultures of people of color there is a recognized interdependence which can be fostered and used to benefit the person experiencing a mental illness. Even when the family has experienced trauma and stress which has rendered the unit unhealthy, the family continues to impact upon the mentally ill member and cannot be negated.

Many of the proceeding papers address outreach and treatment models which have been successful with families and consumers of color. Further discussion should be had with these providers and other mental health professionals of color to discern how these services can be expanded, integrated, or consolidated to provide cost effective, state of the art treatment to greater numbers in the short term.

Recommendation 9

<u>Research should be included, as a part of the Multi-Cultural Mental Health Research and Training Center, which explores coping mechanism used within families and consumers of color, and help-seeking pathways.</u>

Throughout most cultures of people of color, it is apparent that services, through mental health institutions in America, are sought as a last resort. Research into the aforementioned areas may afford mental health administrators and providers insights that will enhance the delivery of services to people of color.

REHABILITATION

Recommendation 10

All Rehabilitation Services should reflect the multi-cultural communities in which they are located.

Housing, Medication Clinics, Vocational Services, Club Houses, etc. should employ staff that have a knowledge of the culture and language of the people within the areas that they serve. Culturally appropriate practices and traditions should be incorporated into the treatment milieu. This should include, but not be limited to, foods; patterns of learning; education regarding medicine and its effects by clinicians with a knowledge of culture; language; and the use of herbs and other substances as medication.

Recommendation 11

Dual Diagnosed Services

The percentage of individuals who are dually diagnosed is steadily increasing. Therefore, programs serving this group need to respond with a variety of services. Included in these services should be long term rehabilitation settings which have the staff capacity to focus on treating people of color who are dually diagnosed. Additional research is needed to help understand the cultural effects of mental illness, substance abuse, and medication, with the goal of the research being to assist people of color who are dually diagnosed to function within their environment of choice.

Recommendation 12

Supportive Education and Jobs

Access to education and jobs is essential to the rehabilitation process. The relationship between work and self esteem is well documented. Programs similar to Boston University's Center for Psychiatric Rehabilitation which focus on supportive education and supportive work must be expanded. Within this expansion, there need to be concrete objectives for addressing issues that face people of color. Casa Primavera and other providers have begun to address these issues and should be consulted.

Recommendation 13   Quality Assurance

Standards set for rehabilitation programs must include the cultural and ethnic diversity of individuals being served within the rehabilitation setting. Quality assurance teams must be representative of individuals who are being served. All quality assurance committees should be formed with representation of the ethnic groups served within a rehabilitation setting. Individuals within the community who represent the ethnic make-up of a rehabilitation facility should be provided the training needed to serve on quality assurance committees.

Recommendation 14   More Community Services - Day Treatment, etc.

In spite of constant cutbacks, the need continues for an increase in community based services for people of color. These services must reflect the multitude of issues facing people of color and advocacy with insurance companies will pay for. In conjunction with an increase in services, professional people of color must receive broad-based and ongoing training which will prepare them to treat individuals who have varying issues. The number of people of color enrolled in helping professions degree programs in the Boston area is very low compared to the number of minorities seeking services within their communities. There are over 30 colleges who should work jointly with human service agencies to actively recruit and/or prepare people of color.

Recommendation 15   Homeless - Housing Models

The debate continues over what to do with the homeless. Never has a group been so visible, yet so excluded from the mainstream of the rehabilitation process. People of color who are homeless seemingly face insurmountable odds. Documentation of the homeless mentally ill of color is limited. Families and young people are an increasing percentage within the homeless. Being homeless, alone, is a dysfunctional situation and exacerbates any illness. We must look at the needs of people who are homeless on an individual basis and assist them in the decision making and implementing process. An array of living situations must be made available. The role of rehabilitation programs should be inclusionary

versus exclusionary. For example, some programs require a "stable living situation" as a prerequisite to receiving services there.

Recommendation 16   **Leisure Programs for the Elderly**

Typical leisure activities for elderly people of color within rehabilitation facilities consists of fairly sedentary events, e.g., board games, card games, and walks. Leisure activities are usually something performed in one's "free time" and are activities of choice. We must survey elderly individuals and ask what they want with the intentions of providing their desired activities to improve and/or increase their quality of life. It is also important to educate them about the many positive effects of more active activities. This process may mean converting resources or creating new resources to meet their expressed desires.

DEPARTMENT OF MENTAL HEALTH SERVICES

Recommendation 17   Research the impact of Managed Care on people of color, the cost effectiveness of traditional services to people of color of different cultural and linguistic backgrounds, and the appropriateness of traditional theory based on a changing, eclectic world.

Recommendation 18   Plans and timelines should be developed by providers to meet guidelines put forth by the Office of Affirmative Action to satisfy cultural and linguistic requirements in the service plan.

Recommendation 19   Each area should ensure that services and providers are culturally and linguistically appropriate to the population of the area.

Recommendation 20   Each emergency service unit should have clinicians of color who represent the cultural make-up of the area served. These units should have someone who speaks the language most prevalent in the area and resources available to them to facilitate other languages spoken in the area.

Recommendation 21   Contractual arrangement with persons from community organizations, Churches, and other groups that have ties to the various cultural/linguistic groups should be explored in order to facilitate diagnosis and treatment.

Recommendation 22   Case Managers should reflect the population of the <u>area</u> they serve. Information should be made available to all case managers regarding services available to people of color throughout the state.

Recommendation 23   The percentage of children of color within the system is significant. The impact of stereotypes upon diagnosis and treatment results in costly and ineffective service. There is a need to integrate more professionals of color in the delivery of services to children and adolescents.

Recommendation 24   <u>**Culturally appropriate supports must be put in place to accommodate separation for adults and children.**</u>

Children of adults with a mental illness need an environment which causes the least disruption to their lives. Family and community resources should be a first alternative. All options should be culturally compatible. Children with a mental illness should be served in a culturally appropriate environment. The Casey and Ventura models warrant particular consideration in the delivery of services to children and their parents.

Recommendation 25   <u>Forensics</u>

Like other areas of the mental health system, there are a scarcity of clinicians of color within the forensic mental health system. This lack of diversity can have unfortunate consequences for the users of this system. This is especially clear in the area of evaluation and assessment. Critical decisions are made based on the outcome of clinical evaluations. It is important that these evaluations reflect relevant issues of racial and ethnic diversity. The appropriate questions must be asked and all clinicians must be willing to explore cultural perspectives and norms which differ from their own.

HUMAN RESOURCES

If a commitment is made to serve people of color, then it is necessary to:

o   Identify mental health professionals and workers of color within and outside of the system throughout the state to be used as potential resources.

o   Maximize the utilization of staff of color to enhance services to people of color and to educate other staff.

o   Institutionalize various components, such as the Multi-Cultural Committee and the newsletter as well as the Multi-Cultural Mental Health Research and Training Center and Grand Rounds, to provide on-going education to all staff.

Recommendation 26   **An environment conducive for growth and professional integrity must be established for people of color.**

Glass ceilings, double standards and other devaluing activities experienced by people of color are products of White ownership and mirror the racism and oppression of society. People of color are blatantly told not to apply for certain positions and are then required to train the White newcomer. When competing, different standards are applied to disqualify applicants of color. Stereotypes influence day to day treatment of employees of color. In times of change, Whites are aggressively repositioned, redeployed, and assisted in finding other positions.

People of color are expendable. This is known and, for the most part, accepted by all. Hence, they take the jobs afforded and do a better job than most in order to maintain them. Opportunities rarely exist that are challenging, and when they do, attitudes and other variables are factored in to diffuse accomplishments and diminish the significance of the act and the person.

Recruitment and retention would not be problematic in an open, receptive, and competitive environment. If theoretically the free market were operable, information would be uniformly available to all, anyone could compete, and decisions would be made objectively. Preference for skin color would not be a consideration.

Recommendation 27   The issue of credentials and equivalency should be explored as a means to incorporate the talent of persons of color who received their academic standing in another country. The practice of viewing these educational credits as substandard and/or elevating position requirements without consideration of prior experience when considering persons of color have served as a means to exclude their participation.

People of color consistently find themselves competing with Caucasians who have no degree, a minimal degree, a degree and no experience, degrees totally unassociated with the position, experience by virtue of admission to positions because of their skin color and on-going support and promotions, or no degree and no experience. Recognition of prior education and experience is necessary to begin to level the playing field. This has nothing to do with affirmative action, only good business and human action based simply on talent. Once this is done, the same supports - information and training - should be available for all.

Recommendation 28   Persons indigenous to the community being served should be incorporated into the work force to better serve its residents.

PROVIDERS

The suggestions for the category of Human Resources is applicable for Providers of Color.

Recommendation 29   Again, given the free market theory, information regarding expectations and needs of the Department should be made readily available to all. The environment must be receptive to new comers, and competition must be opened without consideration to skin color and historical involvement, but who can best serve that community.

o   Include information in Multi-Cultural Advisory Committee Newsletter regarding the Department, its expectations and needs.

o   Disseminate this information widely, include universities, businesses, community organizations, current staff and providers, etc. This will generate interest and, perhaps, encourage the development of new providers.

Recommendation 30   Explore Mentoring Programs

o   Providers of color and/or individuals of color can be mentored within an accepted agency, given authority over various contracts, build a separate infrastructure, then spin-off.

o   Employ and support persons of color who have provided services in other countries with a distinguished track record, while they go through the licensing process here.

o   Consider short term, revocable contracts for service providers who have not previously served the DMH population, but who have an outstanding track record.

o   Establish a vehicle to support providers of color.

The recommendations provided here have emanated from the Symposium for Professionals of Color. They are not new, nor specific to the Department of Mental Health in Massachusetts. They are predicated upon all persons being actualized as human beings, privy to the ownership of this country, and substantial contributors to its existence and continuation.

MEDICATION-PSYCHOEDUCATION GROUPS
WITH LATINO CLIENTS

**Sara Trillo Adams, MA, Maria Del Rio, M.Ed., Doris Smith, M.Ed.,
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Introduction

Latinos confront a unique set of obstacles in obtaining adequate mental health services. Research has shown that language barriers can lead to misinterpretation in treating Spanish-speaking psychiatric patients (Kline, et al., 1980). Experimental evidence has also shown that more psychopathology has been attributed to bilingual Spanish-American psychiatric patients when interviewed in English rather than in Spanish (Marco, Urcuyo, et al., 1973).

Limited Spanish fluency and poor understanding of the cultural background of the patient can lead to misdiagnosis and ineffective treatment interventions (Kline, 1969). It has been suggested that the clinician's frame of reference is an important factor to be taken into account. "What is applicable to native English-speaking patients cannot be directly applied to the evaluations of persons from other cultures" (Marcos, Alpert, et al., 1973, p. 549).

In addition to linguistic and cultural barriers there are other factors related to socio-economic status, migration experience, and acculturation that contribute to restricting access to available health services for Latinos (Council on Scientific Affairs, 1991). Further exploration of these factors is beyond the scope of this paper, but should be taken into account when working with this population.

Existing mental health treatment resources are often limited and sometimes inadequately designed and staffed to respond to the needs of Latinos. It would be ideal to have more bilingual-bicultural mental health professionals working in the public and private sector as well. However, this is not always possible and efficient and clinically appropriate treatment models need to be adapted to bridge the linguistic and cultural gaps while ensuring the quality of services. Community mental health centers are at the forefront in confronting this reality.

Community Healthlink's Outpatient Hispanic Program has been providing psychiatric services to the Latino community of Worcester since 1985. Our current staff includes four bilingual-bicultural clinicians, one of whom serves as program coordinator, and a Spanish-speaking psychiatrist. Two bilingual-bicultural D.M.H. case managers also participate in the clinical activities of the multidisciplinary team. Since the team's establishment, our mission has been to offer psychotherapeutic

interventions, psychoeducation, medication treatment, and support and advocacy for our clients using culturally relevant and clinically appropriate approaches.

In 1989, the departure of our bilingual-bicultural psychiatrist left us with a large caseload of Spanish-speaking clients and a non-bilingual psychiatrist. Coincidentally, one of our clinicians, and former program coordinator, also left at about the same time. The team chose a medication-pychoeducation group modality to continue providing clients with psychiatric services that were linguistically and culturally appropriate. The group setting included a bilingual-bicultural clinician and the non-bilingual psychiatrist.

The utilization of non-clinical interpreters was not pursued to minimize translation inaccuracies. Fazquez and Javier (1991) have identified five commonly made errors by interpreters: omission, addition, condensation, substitution, and role exchange. Other sources that introduce distortions into the evaluation process, such as defective linguistic skills and the interpreters' lack of psychiatric knowledge have been identified (Marcos, 1980).

Medication-psychoeducation groups have been recognized as an effective means of providing medication treatment while promoting patients' compliance through education on issues related to symptoms of their illness, effects of medications and side effects, and increased interactions with their peers (Isenberg, et al., 1974; Cohen and Amdur, 1981). These groups have been effectively used in our outpatient department.

Our experience has shown that, although initially started out of necessity, the groups have turned out to be an effective means of providing much needed psychoeducational, psychosocial, and psychiatric services. A similar experience has been reported by Abramson and Lopez (1988) in working with Latino clients at another Central New England community mental health center.

METHOD

In preparation for the development of the groups the staff and clients discussed, in individual sessions, the purpose of the groups and what to expect. It has been our experience that Latino clients are not receptive to group therapy, therefore the staff emphasized that these groups would be implemented as medication evaluation/education groups. Encouragement and support was offered and collaboration was asked since the change in staffing was evidently stressful for clients and staff as well.

Clients' opinions were taken into account as to whether to have groups of men and women together or separately (their choice was to have separate groups) and they were given a choice on whether to attend morning or afternoon groups in order to facilitate attendance.

Most clients are native of Puerto Rico who have been living in the mainland for over ten years and frequently travel to the island. With the exception of nine members who live alone, most live with their family of origin, extended families, or partners. One member is a Cuban refugee and another member is an immigrant from the Dominican Republic. The age range is from twenty-five to seventy-four years of age. The average educational level is fourth grade. Some clients are illiterate in Spanish, this prevents them from learning a second language and from taking advantage of written materials. All members are unemployed and receive some form of public assistance or social security benefits.

The clients were assigned to groups in random fashion in terms of diagnoses, and types of medications. Other factors such as clients' ability to wait and listen, and stability of symptoms were also taken into consideration. Some clients were not suitable for group due to the severity of their symptoms, poor motivation, or serious reluctance to participate.

In the past three years, a total of sixty clients have participated in eight groups which meet for approximately two hours once per month. An expected number of discharges and new admissions have taken place, with groups maintaining a minimum of three (currently considering candidates to join this group) and a maximum of nine members. To add new members to a group, the option is presented in an individual session, group members are informed in advance, and they are introduced at the next regularly scheduled meeting.

Forty-three clients continue to meet regularly. There are five groups of women and three groups of men. Three groups meet in the morning, and five groups meet in the afternoon. Approximately thirty clients are seen in individual therapy for at least one hour per month. The others meet in group and request individual sessions as needed. A brief description of the membership composition of each group appears below:

Group 1: Five men, ages 35-74. Diagnoses: major depression with psychotic features: one; psychotic disorder, NOS: one (with a secondary diagnosis of mild mental retardation); schizophrenia: three. A member diagnosed with bipolar disorder has recently been discharged as he is serving a legal sentence unrelated to his psychiatric condition. It is expected that he will return to re-engage in treatment.

Group 2: Seven women are currently involved, ages 36-55. Diagnoses: major depression: four (three with psychotic features); schizoaffective disorder: two (one has a secondary diagnosis of alcohol abuse, in remission); dysthymia: one. Three other women participated for over a year, one of then terminated treatment after sustaining remission of symptoms for an extended period of time. Two transferred their treatment to facilities closer to their homes.

Group 3: Seven women, ages 43-58. Diagnoses: schizophrenia: one; schizoaffective disorder: one; bipolar disorder: one; generalized anxiety: one; dysthymia: two; major depression: one. A member who participated in this group for over two years sought services at another facility closer to her home due to transportation difficulties.

Group 4: Four women, ages 44-63. Diagnoses: major depression with psychosis: three (one client with a secondary diagnosis of personality disorder, NOS., another with symptoms of PTSD); dysthymia; one. Two members initially involved in the group (also with diagnoses of major depression with psychosis) no longer participate. One requested to be seen individually (she also has a secondary diagnosis of borderline personality), the other terminated treatment stating she was being seen by a private physician.

Group 5: Three men, ages 42-53. Diagnoses: major depression with psychosis: one; generalized anxiety: one; schizoaffective disorder: one. Initially two other members participated in this group, one of them for approximately one year and then moved to Puerto Rico, the other recently terminated treatment after sustaining remission of symptoms and sobriety for one year (client has a diagnosis of major depression with psychosis, in remission, and alcohol abuse, in remission).

Group 6: Five women, ages 38-62. Diagnoses: schizophrenia chronic: one; major depression: two; dysthymia: two (one of them with additional diagnosis of generalized anxiety). There were two other members of the group who requested transfer to other facilities because of change in address. One client with a diagnosis of schizophrenia, paranoid type, requested to be seen individually after being discharged from the hospital.

Group 7: Eight women, ages 36-59. Diagnoses: major depression: five (three with psychotic features); dysthymia: one (also with symptoms of PTSD); schizophrenia; one: bipolar disorder; one. Another member of the group participated for one year and terminated treatment after sustaining remission of symptoms for over six months (diagnosis of major depression).

Group 8: Four men, ages 25-53. Diagnoses: schizophrenia: two (one with secondary diagnosis of alcohol abuse); schizoaffective: two. This group initially had eight members. However, two members are currently serving legal sentences related to charges of assaultive behavior while under the influence of drugs. It is expected that they will re-engage in treatment for their psychiatric conditions and to deal with their substance abuse issues. One member moved back to Puerto Rico permanently.

The groups are conducted in Spanish with appropriate translations by the therapist, as needed. During the first year, two case managers who worked closely with the team and were familiar with the clients, occasionally co-facilitated with the non-bilingual psychiatrist.

The first part of each meeting usually consists of group interaction, making appointments for individual sessions, discussion topics of interest in the community, and making announcements about upcoming group dates, and other activities. Specific problems such as those related to accessibility to entitlement programs, community resources and housing information are often discussed. Staff and clients share their knowledge of resources.

After this initial interaction, each client has the opportunity to discuss his/her medications with the psychiatrist in order to evaluate their effectiveness and possible side effects. At times, patients request to speak to the psychiatrist in private. This is accomplished by either separating from the group while the other members continue to interact, or by patients stating at the beginning of the group that they would like to be seen last for privacy. Members are respectful of this and many have taken this opportunity. It has been noted that, as patients have become more comfortable in the group situation, the requests for individual meetings have decreased.

The psychiatrist takes notes, documents informed consent, and records side effects observed and/or reported by the client. Our clinic uses a form of physicians' notes which allows for easy documentation of these important observations. One psychiatrist preferred to write prescriptions within this process, our present psychiatrist prefers to phone-in prescriptions at the conclusion of each meeting and only writes prescriptions for controlled substances.

Information regarding the most commonly prescribed medications is presented by the therapist and the psychiatrist. Many clients bring other medications, that they receive for health problems, and ask questions about them. In many instances, they are seen at other facilities with an interpreter and therefore are reluctant to ask about their prescriptions or drug interactions. Their alliance with the providers and group members empowers them to ask these questions. Recommendations and encouragement to follow-up with their physicians are often given.

Some family members, who usually accompany clients to the clinic, have been participating as members of the groups. Initially the patients asked the family members to join in, the staff was consulted, and it was agreed that as long as no one had any objections this practice would be allowed. In three cases, they have been attending almost as consistently as the patients themselves for the past three years. Issues of confidentiality are stressed in all groups.

RESULTS

We have found that through the medication-psychoeducation group experience the clients have been able to form therapeutic alliances with psychiatrists

from different cultural backgrounds than their own while establishing supportive networks among themselves. Attendance has been improved and by maintaining regularly scheduled monthly appointments (i.e., meetings are on the same day of the week, same time of day) even clients who have serious memory problems seem to keep track of their appointments more effectively. Clients also remind each other of upcoming group dates.

We believe that clients have gained understanding regarding the symptomatology of their illnesses and the effects and side effects of the medications they take. Clients have also been able to learn from each other in terms of finding similarities and differences in the problems they are having with social adjustment and medication. The understanding and knowledge they have gained in these groups have resulted in improved compliance with treatment and improved ability to cope with stressors. The following case vignettes illustrate our experiences with these
groups:

Case 1: F.T. is a 38 year old Puerto Rican woman divorced mother of three children, two living at home. She has been diagnosed with chronic schizophrenia and has difficulty performing activities of daily living. Her emotional problems started at age sixteen with a suicidal attempt. She has had numerous psychiatric hospitalizations, sometimes as many as four in one year, since 1979.

F.T. has very low tolerance to stress, she is mostly non-verbal, displays some psychomotor retardation, and has problems establishing relationships outside of her immediate circle. Her participation in the group was facilitated by her mother who quickly became an active member in the group.

In time, she has become more at ease and has been able to laugh and enjoy the group camaraderie. She also has become more demonstrative of affection and has been included in the conversations of other group members. Although she remains somewhat verbally withdrawn, her non-verbal communication, as observed inside and outside the group situation, demonstrates her trust of providers and her learning from the group interactions.

F.T.'s hospitalizations have decreased dramatically (only one in the past three years). Her compliance with treatment has increased. Her mother has become an ally in the therapeutic treatment and has gained from the psychoeducation component to help her daughter with compliance and to encourage her to report on symptoms and progress. From the frame of reference of the Anglo-American culture, the mother's participation could be perceived as a barrier to treatment. However, within the context of Latino family values and involvement, by establishing a therapeutic alliance with both, it is more likely that F.T. will continue to be involved in the group while also engaging in individual therapy to work on improving her sense of self-sufficiency. The intensity of a one-to-one relationship with her therapist to begin with may have been too much for her to handle.

Case 2: M.T. is a 43 year old Puerto Rican woman with diagnosis of major depression. She has a hearing and speech impediment. She is illiterate in both Spanish and English languages. She has been married to an alcoholic husband for thirteen years. In 1990, she joined a medication group with some reluctance. Her speech impediment and her fears of rejection had always prevented her from talking comfortably in front of strangers. Her participation in this group was a challenge for her

M.T. was unconditionally accepted by the members of the group. They were supportive and patient when listening to her stories. This trusting atmosphere encouraged her and she has been able to expand her social network by growing closer to other women in the group. Gradually M.T. has become more open to talking about her struggle with her husband's alcoholism. The information shared with other members who have had similar experiences, and their supportive encouragement have helped her to become more assertive and independent from him. Although her family environment has become increasingly chaotic, M.T. has been able to cope with her life stressors without significant increases in her medications.

Case 3: Miss R is a 44 year old Puerto Rican woman single mother of one child. She has a diagnosis of major depression with psychotic features, currently in remission, and a secondary diagnosis of personality disorder, NOS. She has a long history of psychiatric treatment and has been well known at local hospitals' emergency rooms where she frequently presented with multiple somatic complaints, uncontrollable crying and agitation.

Historically, Miss R has had a low tolerance to environmental stress and becomes easily frustrated by the demands of single motherhood and interpersonal relationships. Under stress, she had a tendency to declare that medications were no longer effective and therefore she requested increases and/or changes in her prescriptions.

Initially, Miss R was reluctant to join a group as she felt that she would not be able to get along well with others. She did have some interaction difficulties at first. However, she slowly began to participate more actively in the group, benefitting from the psychoeducation component and learning the appropriate use of medications. The supportive environment and the therapeutic alliance with the staff allowed her to understand that medication alone could not fully help her.

Miss R is no longer taking an antipsychotic medication and she has ceased to make frequent requests for medication changes. She has stopped her routine visits to emergency rooms for emotional distress. She has been actively involved in individual therapy as well. Although initially isolated and withdrawn, she has been able to establish social relationships with other members that extend outside of the clinic setting.

Case 4: S.R. is a 69 year old Puerto Rican man with a diagnosis of chronic schizophrenia and a history of alcoholism. He has maintained sobriety for over ten years. He has had several long-term hospitalizations in Puerto Rico and in the United States. He has lived in the mainland for approximately fifteen years.

S.R. had been participating in a group for almost three years and has remained stable with no significant changes in his medications. A daughter, with whom he lived, often accompanied him to the meetings. Initially, he was quiet in group although he seemed to be actively listening as evidenced by his smiles and facial expressions. Gradually, he began establishing conversations with other members and inquiring about them when they were absent. On one occasion, he shared that his elderly father had recently died in Puerto Rico. Both the staff and clients offered their support and condolences.

Approximately six months ago, S.R. announced that he was moving to another state with his daughter and her family. The group wished him well and vice versa. Three months later ,S.R. returned to the clinic to request re-engagement in treatment. His medications had been changed and he did not feel they were very helpful. He resumed his previous medications and seemed to feel as comfortable in the group as if he had never left. The other members also accepted him back in the same manner.

S.R. needed to be hospitalized within one month of his return. Upon discharge, he continued to participate actively in group. Other daughters, who live near him, have met with the staff to establish a supportive network for him. It may be argued that one cannot objectively determine whether S.R.'s decompensation can be attributed to the change in medication, change in clinic setting and treatment modality, and/or the separation from his daughter. Most likely all these factors contributed to the problem. The fact remains that he firmly expresses his satisfaction with his treatment and his trust of the providers.

DISCUSSION

Our experience has shown that the medication-psychoeducation groups are an efficient and clinically effective means of providing pharmacological and psychotherapeutic interventions with a linguistically and culturally appropriate context. We have found several advantages and disadvantages to the use of this approach which we describe below:

Advantages: 1. Communication between the psychiatrist and the clients is facilitated (and made possible when the psychiatrist is not Spanish-speaking) by the bilingual-bicultural therapist who can help the process in terms of linguistic skills and in terms of identifying cultural attitudes and beliefs. 2. The psychiatrist can see the client from a non-medical perspective and within a social context. 3. The clients

have more time to interact with the psychiatrist and the therapist which strengthens the therapeutic alliance. 4. The combined clinical observations and sharing of clinical impressions promotes learning and professional growth. 5. Comfortable setting where the staff can interact somewhat informally among themselves and the clients, which is less intense and intimidating for some clients. 6. The group situation supports compliance, and promotes learning regarding symptomatology, use of medications, and community resources. It also offers an opportunity to establish social contacts.

Disadvantages: 1. Confidentiality can not be completely ensured. We have not heard of any problems in this area, but we routinely stress confidentiality in all groups. 2. The group interactions can be distracting, and even if the psychiatrist is Spanish-speaking, the flow of information can be overwhelming. 3. Some clients may disclose information less readily than in individual sessions, particularly if they are new to the group. 4. Due to the linguistic and cultural gaps, the groups are more demanding for all involved. Optimally, we recommend that providers working with individuals from different cultures and ethnic backgrounds be bilingual-bicultural.

For the purposes of this paper we have not attempted to offer data with statistical significance regarding the effectiveness of these groups, further study is needed. Our goal was to share our experiences and to suggest that the medication-psychoeducation group modality can be implemented in other settings where there is the need to bridge cultural and linguistic barriers.

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THE HISPANIC UNIT OF MASSACHUSETTS MENTAL HEALTH CENTER

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In 1981, Massachusetts Mental Health Center (MMHC) was faced with the problem that part of its catchment area (Mission Hill, Allston, Brighton, Roxbury, the Fenway and Jamaica Plain) had a large Hispanic population, and it was not capable of providing adequate services due to the lack of professionals who spoke Spanish and were familiar with the ethno-cultural background of the Hispanic population. Also, there was a scarcity of well trained Hispanic providers who were familiar with the Hispanic patient population and who could function well in as complex and highly competitive a system as MMHC. Added to this is the fact that the population served is a difficult one, due to its being poor, unskilled, lacking education, severely or chronically ill, and having problems of adjustments to the new society, illegality, prejudice, and trauma suffered during migration or in their native countries.

MMHC decided to employ a USA trained psychiatrist of Hispanic origin who had worked in Latin America and the USA and was fluent in both languages and familiar with the different cultures of Latin America and the USA. She was also familiar with the MMHC system and the mental health facilities of the Greater Boston area. Her task was to design a program that would meet the needs of the patient and function within the institution and to train personnel to implement it.

The design of the program and its implementation were done simultaneously with the training of personnel. For the sake of clarity, they are described separately in this paper.

Program Design:

MMHC, founded in 1912 as one of the nation's first psychiatric teaching hospitals supported by public funds, is still a rare combination: a community mental health center that provides its own inpatient services and, through its affiliation with Harvard University, is also a training and research center.

It provides services to the residents of a geographically defined catchment area in Boston, including Allston, Brighton, Jamaica Plain, Mission Hill, the Fenway, parts of Back Bay and the town of Brookline.

It includes over 40 separate, coordinated programs, among them: inpatient services, outpatient services, crisis teams, continuing care for chronically ill patients, half way houses, a children's unit, and school consultation teams.

To design a culturally syntonic program that would meet the needs of the Hispanic population, avail them of the variety of services that MMHC offers, and at the same time could operate in such a complex system, was a major task.

After recruiting a number of bilingual and bicultural professionals (psychologists and social workers), each of them was assigned to one of the outpatient-crisis teams. That is, the Hispanic Unit (HU) member worked with the Monday team, one with the Tuesday team, and so on. It is important to emphasize that they were active members of these teams and took part in all the meetings, case presentations, discussions and decisions regarding both English and Spanish speaking patients. They also would sensitize and point out culturally relevant issues to the non Hispanic members of the teams.

At the same time, all Hispanic providers met once a week and reviewed all the Hispanic patients that had been seen during the week so that all providers were familiar with all Hispanic patients. Culturally important matters were discussed in depth during these meetings.

To provide telephone emergency and triage services, our secretary was trained to perform these services, and to work in close relationship with the Hospital's crisis and triage teams. The Hispanic psychologists assigned to the specific day would provide clinical back-up.

The Director of the program met on a weekly basis with all the outpatient supervisors to discuss difficult cases and policy decisions. This integrated the HU at a decision-making level. The integration of the HU with Continuing Care was accomplished in a similar way. One Hispanic provider was assigned to each of the Continuing Care Teams and the Director of the Unit rotated through the five teams to provide continuity of care and medical back-up.

Due to lack of funding to hire more personnel, when our chronic patients needed services at a Day Hospital, Social Club, Rehabilitation or Half Way House, we could not use the MMHC facilities when the patients were monolingual. We solved this problem by developing close ties with other institutions providing these services to Hispanic patients.

Our work with the inpatient services needed a different model. In order to provide continuity of care, when a Hispanic patient decompensated and needed to be hospitalized, the clinician who took care of him as an outpatient would continue to be the primary clinician while the patient was hospitalized. The inpatient resident would act as medical back-up and administrator, and both would work together with the multidisciplinary team to which the hospitalized patient had been assigned. The Director of the HU would be called upon as a consultant when needed.

One of the HU psychologists who had special training in child psychology was assigned to be the liaison person with the Children's Unit and the School Consultation Services. When the child's dominant language was Spanish, the HU would work with the child and the family. If the child was English speaking, the MMHC Child Fellows would be the primary clinicians for the child and the HU would work with the family who usually was Spanish speaking.

With this integration and coordination of services, at present the HU is able to provide the following services: crisis intervention, evaluations, inpatient treatment, medication clinic, psychological testing, short term and long term treatment to individuals, couples, families and groups, as well as continuing care to the chronic and severely mentally ill.

Conserving a Sense of Identity and Achieving Integration:

The most difficult thing to achieve was to integrate the HU to the whole system, yet continue to have a cohesive unit that Hispanic professionals could relate to, that could give them some identity and constitute a supportive group. This was very important because some of the mental health workers who had arrived recently, had been trained in a different country and were not totally fluent in English. Others had not lived long in the country and had been victims of prejudice which rendered them vulnerable. A last group, by far the smallest, were born in this country from Hispanic parents, wanted to discover their ethnic background, but felt confused and ill at ease with their own identities.

The Hospital itself had had a negative experience with ill-trained persons who spoke Spanish but were not professionally capable, and looked upon Hispanic providers as less capable than the English speaking professionals.

The first decision taken was to hire and train only professionals who had an excellent background so that they could feel equal to their Anglo counterparts. They were not allowed to translate for other professionals. Time and again we made the point that if a Hispanic patient needed services, the Hispanic professionals were better equipped to provide the needed services. They were just as good mental health workers and had the added advantage of speaking the language and knowing the cultural background. This gave our staff security and good self esteem. To have the rest of the Hospital acknowledge the competency of the HU professionals was a hard battle, but we won it by working hard and proving our professional capability. At present, members of the HU are respected as capable and hard working professionals.

The second measure goes hand in hand with the training program. We devoted one hour a week to didactic seminars in general: psychological theory, treatment and modalities, psychopathology, use of the DSM-III, etc. to strengthen the staff's knowledge. We also studied in depth, issues of transcultural psychiatry, especially those pertinent to the different sub-groups of Hispanics so that the HU

staff could develop an expertise in this area. I must remark here, that it was a surprise to me how even among Hispanics, one subgroup knew little about the other.

One hour a week was spent in reviewing cases thoroughly so that the staff would feel comfortable with their cases and presenting their position with the rest of the MMHC staff. We also had an hour of support group. This hour was spent in two different ways. For example, if a provider had to present a case at Grand Rounds and felt threatened because it was his or her first presentation and doubted his/her capacity to do it well in English, we would do a mock presentation at the HU to increase the confidence of the person and to have him/her receive constructive criticism. The other way this hour was spent was as a support group in which a staff person could bring his/her frustrations, problems or difficulties in working with the rest of the MMHC personnel, or problems that they themselves encountered in the outside world in their own process of integration.

This support group was one of the most useful things. It not only provided support to the workers, but it gave them insight into their own identity and assimilation problems which they could easily identify in their patients.

Training Program:

The training program consists of two parts: training for staff members who have a minimum of a Masters degree and two years of experience and internships for Masters, and Ph.D. level students of Harvard University, Boston University, Boston College and Lesley College.

A new staff member went through an initial period in which they were assigned a senior staff member as a mentor. First they observed how the senior member evaluated or treated patients, then they did it themselves under the supervision of the mentor. Once it was felt they were capable of working independently they were left to do so, but they always received an hour of personal supervision from a senior person in the HU (usually the Director) and another of their own discipline. They also had a group supervisor for their own groups and supervision from the outpatient-crisis supervisors.

Besides these supervisions, the staff had to assist in the HU training program described in the previous section, and they could go to all the seminars and education activities at MMHC such as: family therapy, behavior modification, psychopharmacology, psychological testing, adult and child Grand Rounds, etc. As can be seen, they took part in the specialized educational facilities that the HU provided and in the educational facilities provided by MMHC to all its staff, trainees and students.

For the Masters and Ph.D. students, a special program to meet the needs of their Universities was developed between their University advisor and the Director

of the HU. Again, they took part in the programs offered by the HU and by MMHC and were assigned a staff person of the HU as their mentor-supervisor.

This training program proved to be very efficient because the participants learned both the general topics in psychiatry, psychology or social work, depending on their discipline, and the specialized transcultural training. Behaviorally, they also learned to feel comfortable with both Hispanic and American professionals and came to terms with their own ethnic identity.

To date, the HU has trained 25 professionals, who stayed an average of 3 years in the program, and 15 students. We are proud to state that most of the professionals are in leading positions in different programs and Universities throughout the Country.

Conclusion:

I have presented this program as a model that can be used by other institutions dealing with minorities with different language and cultural backgrounds. I believe the greatest achievement of the program is that it has delivered excellent care to the Hispanic population since 1981 and that it has formed a group of professionals who can manage both majority and minority patients, feel secure about themselves, and are now leaders in the mental health field.

It is with great pain that I have to state that due to budgetary constraints, our program has been cut by more than one half, and that we will no longer be able to provide such excellent care to all our patients or form capable mental health professionals.

CROSS CULTURAL SERVICES:
HEALTH AND EDUCATION SERVICES
SALEM, MASSACHUSETTS

Zarita A. Araujo, LICSW

In this paper I will be describing the Cross Cultural Services at Health and Education Services (HES) in Salem/Peabody, MA. I have been working with this team since 1985 and became it's director in 1986. When I started to work with HES, the team was going through major losses. All of the clinicians who had worked on the team for the three years before were leaving the agency due to life changes.

This team could not have existed without their pioneering work and their dedication to serve the cross cultural populations with high level clinical services. Most of all, the Executive Director of HES, Dr. Bill Madaus, and the HES board members were crucial and true believers that a Cross Cultural Team was of great value to the agency and the communities we serve.

Presently, what has made our team so unique is its multidisciplinary staff from all over the world. This includes clinicians and support staff. It is a pleasure to go to work and be reminded that we are all working for the same mission. We all want to provide the best clinical services with the most sensitivity towards each individual/family's cultural, socio-economic and linguistic needs. This is not an easy mission, when a great majority of our clients are at or below the poverty level.

As I will be describing the Cross Cultural Services, just remember that how we develop our team is appropriate for the population that we serve. However, some areas of the State with a different Latino population, might want to develop clinical expertises mostly appropriate for their populations.

Our team serves mainly the Latino and Portuguese populations in the North Shore area, (Salem, Peabody, Beverly, some parts of Gloucester, some parts of Lynn). The Portuguese population is mainly from one of the nine islands of the Azores in the North Atlantic, Graciosa. The majority of the clients we see are the working poor. They work in two jobs, usually unskilled labor at low wages. They might own a house and a car. They get referred to our team by former clients, a local agency for the poor, (NSCAP), local schools, DSS and local Court. They usually have private insurance which only pays up to $500.00 per individual on a yearly basis. The parents usually are fluent in Portuguese, do not speak English and the children are fluent in English and do not speak Portuguese well.

The Latino populations come mainly from three different countries, Dominican Republic, Puerto Rico, and Colombia. We also have had clients from other countries not mentioned. A great majority of our Latino clients suffer from

Post Traumatic Stress Disorder with another axis 1. We see many Latino families with a child or an adult that is considered high risk. A great number are receiving Medicaid benefits through AFDC or General Relief. We also see Latino clients that are working poor. They work in local factories and nursing homes.

In contrast with the Portuguese community, the Latino communities are recently established in Salem/Peabody areas and they seem to represent a greater variety of classes, racial/ethnic backgrounds. Some of the Latino clients were forced to immigrate not only for financial reasons but due to political factors. It is important to note that the description of the Latino population we see might not be representative of all the Latinos living on the North Shore.

Hopefully, the very brief description of the two major populations we serve will help you better understand how we developed our team. We also have several Greek and Asian first generation clients.

The Cross Cultural Team took approximately three years of intensive restructuring and clinician searching. For the first year, the team consisted of two clinicians, each seeing an average of twenty cases per week. Presently, we have a team of eleven staff members. We have changed our name from "Minority Team" to "Cross Cultural" to better represent our work and our populations. Although we all agree that our population often feels the minority, we do not call the clients who have lived in this country for at least three generations as the "majority ". Also cross cultural issues seem to cut across racial, socio-economic and linguistic barriers.

We have recently moved to a one floor building in Peabody, but we use the different HES sites, local schools, clients' homes, local health and human service agencies when appropriate. Our building is smoke free and we have signs in Portuguese and Spanish explaining how to register. In addition we have the Clients Bill of Rights translated in both languages. Both receptionists are cross cultural, speak Spanish and are sensitive to our diverse populations. They receive weekly supervision to help with work stresses and assure full confidentiality of messages and clients at the site.

We have a psychiatrist of an Italian background who has lived in Peru for one year. He is in the process of learning Portuguese and Spanish. A Latino BA level staff translates for the five hour weekly medication clinic. The Portuguese speaking clinicians translate for their own clients and get credit for their productivity standard. This psychiatrist also joins one of the three hour weekly team meetings to go over medication consults and on-going cases.

A licensed, Portuguese second generation psychologist is our team's consultant. He meets with the team three hours per week every other week. He has been a great help with not only our clinical cases but also with the psychological testing component of our team. He directs the Portuguese team at Cambridge

Hospital. He has been one of our major resources in finding clinicians with a cross-cultural and multi-lingual background.

The team is structured in three different levels: director, assistant director/psychometrician program coordinator, program coordinator, school coordinator. We have developed an on-call schedule for the three managers and two other senior clinicians. This will prevent cancellation of appointments when a clinician is involved with a major clinical crisis. In the past when the team was smaller, the clinician was forced to cancel appointments when faced with an emergency.

We noticed that it would become a doubly difficult task to often re-engage clients that were cancelled. We also respect the need for clients to be able to have a primary relationship with a clinician at our clinic. However, we try to introduce our clients to the direct supervisor or intake person as a way to help to develop a positive transference with the agency.

It is our understanding that often our clients are fearful of authority and dubious of mental health services in general. We encouraged our referral sources to begin an initial psychoeducational description of what is mental health. We often call clients after receiving a referral from a local provider. In this call we go over their fears, concerns regarding confidentiality and stigma usually associated with mental health. We meet clients where they are mostly comfortable and where clinician also feels safe. We are trying to pair-up for home visits for safety reasons. Also, an intern might greatly benefit from this experience.

We have hired a well trained BA level Latino staff that is the main intake person. She will always consult with her Masters level supervisor or with the person on call. Our intakes have increased three hundred percent. Our clients seem to need to know names and a brief description of the person they are contacting when calling or visiting HES. This staff member is responsible for all the interpreting and translations for the team. She also keeps statistics of intakes and develops relationships with referral resources. She will call clients and remind them of their appointments. Cases get assigned every day and clients will be contacted within twenty-four hours. We also offer appointments on the same day of the call. The on-call person might have to meet with the client for face to face intake. The clinic is open from 8 AM - 8 PM, Monday - Thursday and 8 AM - 5 PM on Fridays, we have twenty four hour emergency coverage for our clients through HES, North Shore Emergency Services.

The team has developed a short-term model, where the majority of our clients are seen intensely for the first four to five visits, then we move to biweekly and then to monthly sessions. We have an average of twelve sessions per year with our clients. We are constantly negotiating length of treatment and issues to be addressed in the treatment. Often clients only come for the first four sessions and decide to terminate because they are feeling better. What we have learned is that

often these clients will seek our services again within the next two years. This time they seem to know the rules of psychotherapy and are very much ready to work on their issues. It takes at least six months for a newly hired clinician to develop a case load.

The team members have been active in community events and are aware of the needs of our populations. We have developed many programs that address the needs of the DMH mission population. We have developed relationships, and at times contracts, with the local schools in order to provide services to their students and families in need of mental health services.

We have developed close relationships with local health providers and centers. We have developed an HIV/AIDS counseling component, we provide a variety of group treatment for parents, court referrals, school/behavior problems, etc. We have a psychometrician program that serves both languages and has become expert in testing cross cultural clients.

As violence in our society increases, also the number of resistant/violent families has increased. We have developed two programs, one that goes into the homes of clients and helps to assess and encourage families to seek treatment. We also have many women who became psychotically depressed as a result of Post Traumatic Stress Disorder and are receiving financial help. We have developed a program with the local Welfare office where we provide a triage group intervention at no initial cost.

We provide individual, family, group assessment/treatment to all ages. We are always learning and growing professionally as our population lets us know of their needs.

Many more aspects of our team could be described, however I would like to address a very important concern for those of us that want to continue or begin a Cross Cultural Team: How do we recruit staff that are sensitive to cross cultural issues and at least bilingual?

As we develop cross cultural expertise in how to treat clients, we are responsible for making cross cultural clinicians feel respected and wanted for their unique experiences and expertise in the domain of language and cross cultural sensitivity, in addition to their clinical training. Clinicians should be financially rewarded for their extra skills.

The recruitment of Masters degree clinicians who are bilingual or bicultural is a long term process. Our clinic is situated thirty to forty minutes north of Boston. Every time we had a great candidate, we could not afford the salaries offered by Boston area hospitals. Soon, we learned that an effort in developing a network for clinician recruitment was crucial for the survival of our team. The expensive advertisements in the Boston newspapers were never successful.

We began to contact local social work schools and let them know of our program and mission in hiring clinicians that wanted to work with our populations. We began to inform every clinician who had some type of contact with cross cultural clinical services. We developed a local support group for human service providers who were working with the populations we served. Identifying clinicians was only one part of the process. We were able to hire cross cultural, bilingual clinicians, only because HES administration believed and respected our clinical work. This was a very strong message given to the new recruits. When accepting a job with the Cross Cultural Team, clinicians understood that we all needed each other. They were not a number to fill up a quota.

We often were able to see great potential in clinicians who were not trained in the USA, and were still struggling with English as a second language. We encouraged and nurtured these clinicians by suggesting that they join educational programs that best suited their needs. Presently, we are hiring three clinicians who need further schooling in the USA, but who had the foundations for a highly qualified clinician.

We also have trained several graduate level clinicians who are studying in local universities. Some of these students have stayed with us or have gone out of the State. We strongly feel that we are sensitive to students, whose English is their second language. Our team is a safe place for our students. We all work very hard in the different domains that make clinicians competent, compassionate and sensitive to peers and clients.

The Cross Cultural Team is a group of clinicians from all over the world. We represent different classes, different races, different religions. We all have the same mission. We want to provide high quality clinical services that are culturally/racially sensitive. We also understand the needs of different socio-economic clients.

This mission has strengthened the Cross Cultural Team. We all work very hard and show great loyalty towards each other and the agency. However, the development of this very unique trust is a constant process. In this team, clinicians make their personal and professional needs known. We do not always agree with each other, but we work in finding a comfortable agreement.

HES has a great benefits package, especially vacation and maternity time. This has been one of the greatest assets in recruiting bilingual staff. Many of our clinicians have family members living outside the USA, visiting them is expensive. The three to four week vacation is very much needed and appreciated.

Having a Cross Cultural Team as a unit in an agency creates strengths and weaknesses. The strengths are that we all have the same mission or the same exposure by living in a foreign country. We do not have to worry as much about

how you express yourself in regard to a particular client. The team members seem to have less of a need to generalize statements made about a particular cross cultural client. The clinician does not feel the pressure to defend the population served in team discussions.

Clinics who have cross cultural clinicians working with the non cross-cultural teams seem to lose cross cultural clinicians at a faster rate. This could be explained by the fact that in this setting, the cross cultural clinician has to constantly clarify when traits of the client being discussed are those of the client specifically and when they stem from the culture of the client. This can become an emotionally exhausting task, where every word and statement has to be made in a way that would not lead to a particular stereotype of an ethnic group.

It should also be noted that clinics with cross cultural clinicians integrated into the general staff benefit by exposing everyone to language/cultural and racial differences. It becomes a less dichotomous world, of them and us. We strongly suggest that such clinics have Cross Cultural Teams as they have teams with particular expertises such as eating disorder teams or elderly teams. However, clinics should open their clinical positions to cross cultural clinicians who want to work with non cross cultural clients.

HES has encouraged the diversity of clinicians working in the Cross Cultural Team. This includes clinicians who are only bilingual and not bicultural. Diversity makes our team a richer and stronger contributor to the clinical services delivered at HES.

In the last two years, we have noticed a considerable amount of interest on the part of mental health clinics to develop Cross Cultural Teams. It is my understanding that agencies need to communicate with each other in order to better serve our populations, so that services are not duplicated and we still are not serving clients in all the mental health areas so needed.

We feel very lucky to have had the opportunity to work with the cross cultural population in the North Shore area.

TELLING US SOMETHING

Dina A. Carbonell with Jorge Fernandez

School Consultation and Treatment Program
of the Vinfen Corporation

ABSTRACT

This paper describes the perceptions and ideas of seventeen children attending inner-city schools in Boston. The children are participants in a program delivering school-based mental health and prevention services. They are predominantly children of color in elementary and middle school grades. The program's various components, described only briefly, complement one another and attempt to reflect a philosophy of empowerment, multicultural community, and contextual intervention. The staff decided to ask the children themselves about the program and about aspects of their lives that are relevant to effective service designs. The paper is the result of this exploratory verbal exchange.

Program staff talked at length with the children in the Spring of 1992. They elicited their views of the program, of the idea of school-based mental health services, and of their schools' and communities' strengths, problems, and needs. The children spoke about their experiences in individual and group therapy, in prevention workshops, and in their school life as a whole. Their voices and words had much to teach the program. This paper describes some of their difficulties, feelings, dilemmas, relationship issues, creativity, and hopes. A variety of implications for clinical services for children can be extrapolated from their experiences and recommendations.

TELLING US SOMETHING

Dina A. Carbonell with Jorge Fernandez

INTRODUCTION

Children living in Boston's inner-city communities face daily stresses that would perhaps overwhelm the majority of presumably competent, well-functioning adults. Yet these young people, out of necessity more than out of choice, have learned to navigate the dangers, the challenges, and the confusion in ways that make such coping seem second-nature. While we can assume that there is a cost to their efforts, many seem to thrive despite this stress level. One writer on childhood stress (Felner, 1984) has suggested that some aspects of it may occasionally have positive as well as negative consequences for children. One example is the sense of competence that can emerge out of the experience of successful adaptation to difficult circumstances. There is an unsettled question in the literature on resilience on what, if any, level of stress may be optimal to children's growth, challenging them without overwhelming their coping resources.

It seems clear to parents, teachers, and human service providers that the current demands on children living in lower-income urban areas are beyond optimal levels in magnitude and not of a nature that promotes positive coping and development. It appears that children living under such stress need to allocate a significant proportion of their individual and collective resources and creativity for maintaining a sense of life as positive, coherent, and meaningful. This presents a challenge of urgent and devastating proportions to policy makers at all levels of agency and government administration. It is an unnecessary discarding of human potential.

While the current State administration in Massachusetts is arguing over the efficiency of human service programs, social workers in urban agencies face a range of daily dilemmas in their professional lives. They confront the challenges of attempting to meet perceived service needs that are greater than available resources, of feeling helpless and hopeless in the face of sociopolitical factors that appear beyond their control, and of being unsure whether what the profession has to offer is fitting with the needs and preferences of the people it is attempting to serve. And yet by far the greatest dilemma and challenge is that of determining not how to be efficient, but what to be efficient in. As Wildavsky (1991) points out, efficiency in such efforts as the destruction of human beings is hardly to be commended. And yet it is not clear that that is not what our society is doing, directly or indirectly, knowingly or implicitly.

Those in a position to have some control over resources allocated to children face the parallel dilemma of determining what is best for other people. Inner-city children are relatively powerless, at least in any formal sense: they are young, they live in poverty, and many of them experience the oppression of racism and ethnic prejudice. They are told by virtually every social institution that they are worthless, expendable, and to blame for their own difficulties. Their voices are silenced, primarily through omission. They are also silenced through paternalism and other forms of coercive interpretation, both of which can occur within the labeling process in the mental health professions.

In an attempt to make an opportunity for some of Boston's children's voices to be heard, and at the risk of adding further to the misinterpretation or distortion of their opinions, experiences, and stories, this paper presents the results of a small exploratory venture into the worlds of the children who are the recipients of human service programs designed for them by adults. It consisted of conversations between seventeen inner-city children and a clinical social worker in the public schools. All of the children had participated in the School Consultation and Treatment (SCAT) Program's individual, group, or classroom clinical and prevention services. The project was intended to allow one school-based mental health program to hear, literally, what the children who constitute its primary clientele say about its programming, their lives in and out of school, and their own human service needs.

RESEARCH ON CHILDREN AND STRESS

Much research has been done on childhood stress, vulnerability, and resilience using quantitative methodologies and epidemiological approaches that draw conclusions about the cases and consequences of trauma and chronic stress on children (e.g., Du Bois, Felner, Brand, Adan & Evans, 1992; Rutter, 1983). These studies attempt to identify personal attributes as correlates to resilience in children, personal and family factors that mediate the effects of stress, and environmental characteristics that seem to promote or deter children's coping capacities (Eccles, Midgley, Wigfield, Buchanan, Reuman, Flanagan & McIver, 1993; Wyman, Cowen, Work & Parker, 1991). While useful and informative both for further research efforts and for program development, this research raises many questions about the definitions of coping that are used in the field of mental health. These seem to vary from behavioral ones based on adherence to social norms, to theoretical ones founded on the value systems of individual autonomy and traditional conceptualizations of success, to pragmatic ones that center on the absence of problems or of "negative" feelings.

Some media reports on childhood trauma and stress (e.g., Timnick, 1989) give more of a voice to the children and families than do many of the research articles found in professional journals, making their lives more real to those not experiencing violence and validating the devastation and strength that necessarily

emerges from human beings who undergo extreme adversity and survive it. While occasionally sensationalistic and the unavoidable product of a predominantly White, middle-class writers' lens, these reports are accessible to a wide audience. They often provide a less "professionalized" narrative that largely avoids intellectual euphemisms.

A few studies have used in-depth interviewing with survivors of trauma and chronic stress. One such effort is described in Moskovitz's (1985) research with adult childhood survivors of the Holocaust. Moskovitz's study is particularly interesting in its ethical considerations, for she includes data from a follow-up questionnaire that asks her participants about their experiences of being interviewed for the research project. Additionally, in some instances she used the interview opportunity to make deliberate attempts to foster change in the participants' lives, such as her encouragement of one woman to seek counseling. Another such study was done by Dubrow and Gabarino (1989). They interviewed ten mothers in one of Chicago's public housing developments and ten mothers in similar economic circumstances who lived in a nearby community, asking the women about concerns with danger and strategies they used to insure their young children's safety. They identified general patterns and differences within and across the two groups. Perhaps of greater value than the specific findings was the interweaving of their underlying assumption that the women were coping with a difficult reality and the subsequent starting point of looking at how they were doing so.

Research on children and adolescents often omits contextual and political considerations. In focusing on dysfunction and deficits rather than on strengths (Jessor, 1993; Sullivan, 1992), it echoes the missed opportunities of clinicians to use the resources and momentum of positive coping. It is important to acknowledge the limitations of what an individual, family or community can do when faced with difficulties. It is equally important, however, to acknowledge resilience and to use strengths and resources (see Omizo, Omizo & D'Andrea, 1992) in the service of maximizing human potential. The mitigation of the impact of stressful negative events and circumstances in young people's lives (e.g., Larson & Ham, 1993) can be central to the development of primary and secondary prevention programs. The identification of obstacles to coping, including situational and social ones (such as living with immediate danger or with the effects of oppression), and of factors that enhance it also make possible a more comprehensive professional approach to psychosocial well-being.

DESCRIPTION OF INTERVIEW VENTURE

Background and Philosophy

As clinicians within Boston's inner-city public schools for nearly a decade, the SCAT program has come to believe that school-based services could have a strong positive impact on the lives of our young clients and their families. The public

school is the only established institution in society that is virtually universal for children. It is also the first institution with which most children interact directly and which they can imprint with their individual personalities, group identities, and cultural worlds. In addition, our model of service implementation is one that we had all found positive, powerful, and able to promote the goals that were shaped by our values: to make the inner-city world a little safer, more positive and growth-fostering, and more optimistic for and responsible to its younger inhabitants.

SCAT services stress the interactive nature of subparts of the program. Its treatment and prevention activities cover a range of modalities and enhance one another (Cicchetti & Toth, 1992). The resulting web of services, while not devoid of gaps, is a relatively comprehensive one whose components complement and amplify one another's impact on the children and on their environments.

In addition to developing programs that SCAT workers believe will have a positive impact on the children they serve, the program pays attention to its own staff's and trainees' needs. We are aware, often painfully so, of the limitations of what we can do to have a positive impact on the lives of our young clients. Kurland and Salmon (1992) stress the importance of mutual support and understanding when working with clinical and social problems that appear to be greater than the resources available to address them. The parallel process of the children's lives and our own lives as clinicians is an issue that frequently becomes the focus of supervision sessions and staff meetings. We try to provide for each other what we strive to offer the children: attentive listening, making sense together of overwhelming experiences, a broader range of perspectives and alternatives, respect, and the willingness to stay with one another through difficult times.

SCAT programming attempts to facilitate the promotion of children's competence, well-being, multicultural respect, range of life options, and sense of community. Towards these ends it strives to equalize the power imbalances that are inherent in the child/adult, client/professional, and occasional person of color/white person interactions of the children with program staff. A few examples of these attempts are being on a reciprocal first-name basis with the children, negotiating openly around whether and when to meet and what activities will be done (within the constraints of the school schedules and with session agendas that meet stipulations of funding contracts), and the commitment to addressing the children's own goals and concerns through the work. It includes competence-promotion and prevention (see, e.g., Allen-Meares, 1992) classroom programs that focus on issues the children frequently bring up: fears, friendship, violence, decisions, and conflicts. It attempts to respect and make a place for the children's creativity and inherent strengths.

In keeping with its values and goals, the SCAT staff has been incorporating client-centered program evaluation measures. Rather than assume that our perceptions of what we are doing is helpful, we have been eliciting feedback from the children. We have given the children questionnaires, requested verbal feedback

and artwork, and observed their interactions with and about the program. According to Oakley (1981), interviewing can be a reciprocal process that is largely interactive; while she was referring to women in her paper, some of her underlying values about power can inform the process of interviewing children. An awareness of these dynamics can be useful in clinical situations as well as in program evaluation and development efforts such as the one described below.

Choosing Interviewees

In order to select a sample of children who might represent a variety of experiences with and views of the program, a purposive sampling technique was used. Seventeen children were interviewed at three of the six schools in which SCAT is based, using a semi-structured format. One of the interviews was with a triad, three were with dyads, and two of the individual interviews were with children who had a friend present but not participating actively in the dialogue. The children ranged from eight to fourteen years in age and from second to sixth grades. Twelve were girls and the remaining five were boys. Six were African-American, nine were Latinos (primarily Puerto Rican), one was Asian, and one was White and of Irish ancestry.

The three SCAT schools in which the interviews took place are in inner-city Boston neighborhoods. Two are in particularly high-crime areas, and all three have experienced violent incidents in the immediate community during school hours. Most of the children live within the school community or in a similar one nearby. The children had participated in various SCAT program components (individual sessions, duos, groups and classroom workshops), with approximately half having experienced more than one program modality. They had referred themselves or were referred by parents, teachers, SCAT workers, and school administrators for a variety of reasons that included behavioral, emotional, and/or social concerns. Some had been referred because they had experienced traumatic events.

The SCAT team leader at each school, known to the children at that school whether or not she (these three schools all had female team leaders) was actually the child's clinician or workshop leader, selected several children at her school and requested their participation in the interviews. She offered a brief explanation of the voluntary nature of the session, maintaining confidentiality and the purpose of the interviews. The interview sessions were conducted in the rooms used by the program for individual and group sessions. Most of the rooms are small (one was a partially-converted supply closet), are decorated with children's art work, and contain a variety of toys and games.

The interviews began with a repetition of the voluntary and confidential nature of the dialogue and asking the children's permission. It was explained that we were interviewing them openly for the purpose of evaluating the program and gathering their thoughts about children's needs and programs in general. They were also given the opportunity to ask questions about the questions, the format,

and the interviewer's roles in SCAT. The interviews lasted from twenty minutes to slightly over one hour. Most were conducted in English; one was exclusively in Spanish and three were in a combination of both languages. They took place over a three-week period in the Spring of 1992, shorter than might have been ideal but necessary logistically due to the imminent end of the school year.

DISCUSSION OF INTERVIEW CONTENT

Introduction

In most cases, the children appeared glad to have the opportunity to give their opinions of the program and talked readily about their experience in SCAT, in school, and in their home communities. They generally portrayed the program and their participation in it in positive terms, as something of which they were proud to have been part, and as a natural part of the school environment. While it is likely that some of the positive feedback can be attributed to the children's awareness of the interviewer as a SCAT member, their occasional criticisms of the program and the ease with which they spoke attests to their relative comfort in stating their opinions and in talking to an adult once that adult had the SCAT "stamp of approval." The children's generalization of their acceptance of SCAT as an entity, beyond acceptance of their particular counselor, has also been repeatedly noted by staff being addressed by unknown children with: "Hi SCAT!" or by their describing someone as "kind of like a SCAT", as if the program itself had a personality.

A few of the children asked questions beyond the interview process. Two girls asked something about the interviewer's clothes or hair, one second-grade boy about how she enjoyed "helping children," and several children about a song, a teacher or a SCAT staff person they were unsure she was familiar with.

General Experiences in SCAT

Most of the children said that they had begun attending SCAT of their own initiative. This is interesting in comparison to the staff's perceptions that most of our clients are referred by the school, and seems to be reflective of their "ownership" of the program, as does their frequent usage of the terms "our group." A few did mention that the teacher sent them to the program or that their parents, primarily their mothers, wanted them to go. Several children said that the reason for their attending SCAT was their behavior or attitude, which was in some way problematic to others (usually to those referring them) or to themselves. One fifth-grade boy said he initially went to SCAT to get to miss class. Several said they had heard it was fun and wanted to come. One young girl said that

> ...the reason why I came to SCAT is that my father passed away... and there was nobody that I could tell my feelings to, so I came to SCAT and this is where I tell my feelings.

She added that she liked having the program in the school, although she had talked to a social worker in a different setting once and had found it useful. Another fourth-grader said that he also liked SCAT being in his school, because without it "we wouldn't <u>have</u> a school...Everybody would write on the walls." The second-grade triad jointly and gleefully designed a SCAT-only school, in which all their usual school activities would occur within the SCAT program.

Most of the children did not want SCAT to change in any way other than to increase the frequency and/or duration of sessions or to add an after-school component. One fifth-grader liked SCAT's presence in the school and its focus on peer relationship groups:

> Because kids get to know each other, 'cause some kids go from different classes...Some kids go to SCAT, and they're mixed...So, if we don't like somebody, we get to know them more, and see what they're really like... You might not <u>like</u> them that much, but you know that they're not <u>all</u> a bad person; they could be nice <u>sometimes.</u>

One girl stated that she would like the SCAT counselors to talk less, and a few said they found the expectation to talk a difficult or negative one at first, but most said it was eventually helpful in some say.

The children primarily defined their SCAT experience in terms of the activities they did. They described these as: playing games, learning, having fun, getting advice, making friends, making art projects, having parties, going outside, eating, playing sports, reading books, and being with friends. They described the SCAT staff as "nice," as able to listen, as helpful when there was a problem, and as fun.

Talking as a Primarily Positive Experience

One of the fourth-graders, who said that talking had been difficult for him and whom his counselor described as very quiet during their sessions, nonetheless said that talking "made me feel a lot better." He and several other children said that they talked about bad things that happen; a fifth-grade boy stated: "If you talk about them, you don't be thinking about them...And you <u>wanna</u> talk to somebody." The children also mentioned talking in SCAT about problems they were having, things that were on their mind, "things that hurt our feelings," and secrets:

> We talked about important things and we didn't keep anything from each other, and if we had a secret we would tell, because it would be <u>our group,</u> and we promised not to tell anybody but our group. And we talked about everything in our group...

This fourth-grade girl had been in the same peer group for three years. Another fourth-grader at a different school said that the SCAT activities were fun, distracting her from thinking constantly about painful past life experiences, and that playing and talking together were good, "so your feelings won't hurt you."

The children also mentioned talking as helpful when they were able to talk about "your troubles," school rules, other-sex peers, their "attitudes," anger that was expressed in ways that got them into trouble in school, their families, or "anything we wanted." One shy fifth-grade girl who had experienced multiple traumatic life events said that talking was not always easy but "I like it because, then, all your problems will go away, and you won't be sad anymore." While she did continue to be sad over the course of the school year, she was a child who gradually became more assertive about her needs, more outspoken in class, and better able to ask directly for support from her social worker, her teacher, and her classmates.

The initial discomfort of being expected to talk about personal issues in the first few sessions was mentioned by several of the children, although all of them said that once they got to know the clinician and/or the other children, their discomfort decreased and the experience was worthwhile. One adolescent girl who had been having nightmares and panic attacks since the shooting death of an aunt described the experience of talking as embarrassing at first and later as very positive:

> You had to talk to a person you didn't know...Like I was meeting a new friend...It was good, because when I was scared I would tell my SCAT teacher, and she'd help me; she would calm me down.

A fourth-grader who had lost one of her parents to AIDS said that it helped her to talk about negative events and feelings "so you don't cry all the time." Her friend nodded agreement and added that "when you tell somebody what happened, sometimes it makes it better 'cause you told somebody instead of keeping it in your mind all day."

While the opinion of the children is generally that talking about feelings, problems, ideas, values, dilemmas, and concerns is more helpful than not, the theme of their initial discomfort level is one that merits mental health professionals' attention. The message is also clear that once they become familiar with someone, talking becomes much easier and more positive. Current trends in severely restricted length of treatment may preclude many clinical encounters' development into effective treatment relationships.

The children also mentioned that even a slight familiarity with someone, through seeing that person in the school building, knowing about SCAT in general, or hearing about someone from one of their classmates, made it easier to talk with her/him initially. These observations can be useful in adapting program designs for working with children, maximizing aspects that allow them to approach the work

more gradually. We can at least attempt to give them the opportunity to regulate the degree or pacing of their involvement in the therapeutic relationship.

The interview participants responded readily to questions about others in their lives with whom they talk about personal issues in a variety of ways. Most of them were able to list at least two such people in their lives. The majority of these people were family members: parents, a sister, a mother, an aunt, a father, a cousin, a grandmother, a brother, and a godmother. Others mentioned talking with people outside of their families, including a teacher, a counselor, a best friend, and other friends in school or in the neighborhood. A couple of children stated that they talked to no one, with the exception of SCAT, outside of their family, out of concern that their personal "business" would be spread around. One child said that she talked with nobody.

Learning About Oneself

The children talked about this issue in a range of ways. Several referred to having learned to talk about themselves or about feelings, including overcoming shyness, learning "how to share things" verbally, and becoming able to trust their peers. A third-grader who had disagreed with her mother's description of her as a "follower" that got into trouble by going along with other children, and with the subsequent decision by her mother to refer her to the program, said that she had learned that she was "bad." Fortunately, such negative labeling was not a frequent phenomenon. A fourth-grader in the same school said he was relieved to learn that he was not so bad after all: "I thought I was the worst one in school, and then when I went to SCAT I found out I wasn't." Neither of these two children elaborated on what had contributed to their learning of these "facts," but it would be interesting to explore the process further with them.

Other children mentioned learning to become more self-confident, how to be friendly with others, how not to be afraid of threats and what to do if threatened by someone, that they were good at and liked sports, that they had other talents such as drawing or writing poetry, how to stay out of trouble, how to stop crying, "that we got feelings," that what one feels matters more than what others say, how to be assertive, and "that we're somebody." One fourth-grader stated:

> I learned to do the right thing...and if somebody's sexually abusing you,
> or hurting you, or doing something bad to you, you can come to SCAT,
> or one of your friends in SCAT, and talk to them...you can say anything
> you want.

Trusting Others and Making Friends

The children appeared to have clear definitions for themselves about the meaning of trust, whom they were able to trust, and how they developed trust or mistrust of others. Their general trust of the SCAT program was evident through

their ready acceptance of the interviewer, their interacting with her fairly comfortably and easily, and her own perceptions of the rapidly increasing comfort level within each interview. In more global terms, the children usually talked about trust as something related to knowing someone, to the issue of confidentiality and keeping secrets, and to peers sticking up for one another.

The issue of confidentiality was mentioned by several of the children at all three of the schools and defined in similar terms. Primarily, it revolved around keeping information shared with others within the parameters of the relationship, whether dyadic or group. Most of the children felt they could trust in others selectively. One fourth-grade girl said that she chose carefully whom to tell something traumatic that had happened to her:

> I only kept it a secret, and I only told my best friends, not everybody,
> 'cause it would still go around the school, and then people were gonna
> start making fun of me.

Most of the children mentioned trusting SCAT. This included not only trusting the SCAT staff, but other group members as well. Two of the children reported that confidentiality was not kept by other children in their group; one instance involved a girl who had been asked to leave a group because of disrupting it constantly, and the other centered around a racial split. Both occurrences were addressed within their respective groups, but some sense of betrayal and mistrust remained. Several other children mentioned generally fearing that they would be betrayed by classmates, but nonetheless continued to trust those they felt would be unlikely to betray them.

For many of the children, trusting someone was equated with being able to talk with her/him, particularly about secrets or personal issues, and with knowing someone well. One fifth-grade boy said that he had to know his friends for "about a year" before considering them in the category of "close friends" and trusting them with private information. A fifth-grade girl at a different school echoed this process, stating that trusting someone "takes some time." One fourth-grade girl said that it had to be a two-way process: Rotenberg (1991) discusses the expectation of mutual secret-telling and trust-building inherent in children's close friendships. Two girls who were interviewed together and who are best friends described their initial shyness with each other and their subsequent building of a mutually trusting, strong friendship.

The children talked easily about components of friendship and things that friends do for and with each other. They mentioned lending them things, playing together, talking, being nice to one another, telling secrets and experiences, sticking up for each other, being a "team," growing up together (sharing the experience of puberty), having fun, helping each other in school, trusting one another, making the other laugh, and being close "like cousins." Some of the children mentioned characteristics they find positive in a friend, such as being attractive or funny, but

mostly they focused on the friend's actions. Their mention of SCAT as a place to make friends was particularly important for those children who were in peer groups run by the program. Jason and Rhodes (1989) stress the value of children's mutual helpfulness as an important component for prevention programs. The children in SCAT did see the program as consisting of the context provided by peers as well as by the SCAT worker.

The area of friendship and trust is the one where gender differences were most evident, with girls stressing more than boys the need to define the boundaries of looseness, trust, and friendship. Belle (1989) notes this trend and states that it becomes most differentiated when children are in late childhood.

These gender differences suggest that social relationships among girls are more dyadic, exclusive, intimate, and self-disclosing than those of boys, from childhood through adolescence. From childhood to adolescence, girls appear to seek more help and support from others than do boys. Boys may also utilize network members in times of stress, but perhaps more as sources of alternative satisfactions and as distractions from problems than as direct providers of emotional comforting and instrumental assistance. These differences parallel those previously found for adult men and women. (pp 179-180)

As the interviews included only a few boys and did not focus on this area in great depth, it would be difficult to make more general observations about gender differences with regard to trust and intimacy in children's friendships, but as a starting point for more specific studies it is an area that seems promising. It would also be of potential interest to investigate a variety of ethnic and racial groups' similarities and differences in these interpersonal dynamics.

Self-Concept

When the children described themselves, they primarily used terms that referred to physical aspects of themselves rather than to personality characteristics. This may be a factor that reflects a greater ability than that of adults to experience their own essence in physical ways, in the way they feel themselves to be within their bodies. It could also reflect a more concrete interaction with the issue of self-description. Two of the girls who were interviewed together, however, talked about the importance of liking boys for what they were like inside rather than whether they were attractive.

A few children also mentioned seeing themselves as talented, shy, bossy, bad in school, friendly, lacking self-confidence, likeable, healthy, quick to anger, talkative, nice, easy to embarrass, having a "bad attitude," and beautiful. One young adolescent girl stated firmly: "I'm a strong person." Some referred to activities that they did as somehow descriptive of who they were. These included running, fighting, drawing, writing, singing, dancing, rapping, and public speaking. They

were generally things they valued about themselves whether or not others thought they were positive actions or attributes.

One eleven-year-old-girl said that what is important to her about herself is her health and her body. She stated: "What do I like about myself?...I like the way I talk...I like the way I dress...and I like the color of my skin." Several children mentioned skin color and/or ethnicity as an important descriptor of people in general or of themselves.

One Southeast Asian girl remembered a SCAT social work intern of the same nationality who had been at her school the previous year, despite the fact that she had not been her client. The importance of adults as visible role models and sources of validation for children seems to be strong in the area of ethnic identity. It also emerged as important in the children's overall identity, self-worth, and group identification, mentioned often as a factor which they shared or did not share with others. One twelve-year-old Puerto Rican girl mentioned both similarities and differences related to race and ethnicity. She felt that all people are similar in core as human beings and in our ancestry, but that we also have differences in color, lifestyle, food and music preferences, and language. For her and a friend that was interviewed simultaneously, their bilingual life was a source of pride and a point of conflict with monolingual peers who demanded that they speak English.

The children mentioned differences from others as including having their own name, looking unique, and having "different blood" or background. One third-grader stated: "I'm all different ---- all things." Some talked about being like others as stemming from all being human and part of the same world. Others mentioned similarities being grounded in having similar experiences, families, or problems; one eleven-year-old said that most of the time we simply are unaware that others have similar experiences to ours. She had found these commonalities a source of relatedness to others and the basis for friendships for children.

In terms of gender, one sixth-grader stated that men and women are similar because they can do the same things. A ten-year-old stated that boys and girls are different in that more boys sell drugs than girls, although she noted that girls sometimes sell drugs too. Two fourth-graders mentioned boys' tendency to pick on girls, and girls' subsequent need to defend themselves and one another. The area of gender was not explored directly in much depth in the interviews, and with regard to the children's self-concept, it appears to be so pervasive that it has become a "given" that would need to be examined more specifically.

Stories from the Children's Lives

In the course of the interviews, many of the children shared stories from their life experiences. Some of these were about positive events: making spending money, doing odd jobs, winning a car on the radio, making a television commercial, and spending summer vacations with friends and relatives. Others were about

events that were problematic or traumatic: a teacher leaving and attributing it to the children's bad behavior, drug dealing in the neighborhood, violent incidents, going to the hospital, a man exposing himself to a group of second-graders, family deaths, shootings, racial incidents, and memories of war. A fifth-grader reports on the positives and negatives that followed a neighborhood shooting:

> We have a group. It started...the first time they started shooting. And then we didn't want it to happen no more. 'Cause there was a lot of little kids, and they was scared to come outside and everything. So we decided to get a group together...So now we got our own group, and then we're working to get other little kids involved so they can have someone to talk to, and stuff like that.

The children's lives include the daily challenge of coping with exposure to danger, witnessing violence, the loss of friends and family members to violent deaths, and the "side effects" of living in communities that are vulnerable to drug trafficking.

To many people, the children's stories see extraordinary; to the children, they are unfortunately a part of life. They find ways to make some sense of it, if that can be said of oppression, violence, and fear. Their stories tell us a little about the experience of being a ten-year-old dark-skinned child living in one of this country's major cities in the 1990's:

> People are starting to bring drugs in the neighborhood...and people are getting beat up a lot by the same people...It's like someone from a different development comes in and takes over some boys. And then that's how it all starts. They start to do drugs, and they do them on the street, to sell, to smoke weed anywhere...It's like they don't care. And they do it right in front of little kids...But see, most kids know about what is going on out there, so if something happens to them, they know what to expect and what not to expect...To me, a kid should know about drugs and violence, and all that stuff. About what drugs can do to you. It's not, like: "You, don't do drugs," 'cause that's not gonna help..." Don't do it" is like my mother telling me: "Don't go outside." I do it anyway.

This articulate preadolescent is stating clearly that awareness about the stark realities of life in the inner city is not a matter of choice. It is a goal, a necessity, and a result of living one's daily life. What has been referred to by novelists as the innocence of childhood is in this context an obsolete concept. They know the situation in their neighborhoods and have created their own understandings of it. One eleven-year-old informant speaks about teenagers:

> That's the age when they get really close to drugs, and that people start asking them...You can't tell them what not to do and stuff. You can't

say: "Alright, how can you stop doing [or] selling drugs?" They live off of that. That's how they make their money, that's how they get their clothes...It's like a job for them. It's like they don't make enough money. But by selling drugs, they're supposed to make enough money for them to buy clothes, food, house...and still have spending money.

The children's stories reflect a variety of philosophical or ideological constructions of life events and relationships. One fourth-grader tries to focus on the positives since her father's death. A sixth-grader follows the philosophy: "Always look at yourself before you talk." Another sixth-grader talks about thirst as a metaphor, where one could be thirsty for love or for one's country.

Power and Competence

The children talked of experiences in which they exerted power or assertiveness and others in which they felt they had little control or choice. In the interview itself, several of them exerted control by deciding whether to answer questions or not, asking questions themselves, and taking the lead in a discussion or questions put to another child. An attempt was made to make room for and encourage this as much as possible. The fact that the meetings took place in what is regarded as a mutually controlled space in the schools also allowed them to take ownership of the experience. Some of the children introduced the room to be used by saying that it was "our group room last year" or another similar phase.

The children gave many examples of instances in which they have been assertive. This seemed to be associated with a sense of effectiveness or competence. Thompson and Spacapan (1991) speak of this positive function in the perception of control in the enhancement of competence and well-being. One girl who is usually timid at school mentioned being able to tell others to stay away from her when she is angry. Another girl decided to tell a counselor at a medical facility whom she did not know well "half of my feelings." A fourth-grader stands up to the boys in her class; she also gets her own way with her mother. A twelve-year-old says something back to other children who say negative things to her. One young adolescent asserted that if the Department of Social Services should attempt to remove her from her parents' home, as it did with a friend of hers, she would run away to Puerto Rico and then send for her mother. A fifth-grader speaks of a similar community empowerment effort:

...it's your development. They can't come in and try to take over...people are coming and they try to take over, but it don't happen. 'Cause we tell the police and stuff like that. And we work together to make sure it doesn't happen...And we're trying to get all the bad people out of it, so the little kids will feel safer...'Cause it's like being in jail. They get to stay out of their cell, but we in the cell. And we just get so sick and tired of it. And we just want to get them out of there, so we can come outside and have fun, and do what we want to do out there.

The "we" in her description is a clue as to the power of community cohesion in this young person's life.

Several of the children mentioned experiences of powerlessness that they attribute partly to being children in a world controlled by adults. One example of this is the one about needing to run away from DSS. In addition, two of the children talked about relatives who pinch their cheeks. They also mentioned incidents where they had to obey an adult whether or not it seemed fair. A further exploration of this theme could be greatly enriched by probing children's opinions on school rules, fantasies of self-sufficiency, or instances of assertiveness towards adults.

One fourth-grader mentioned feeling powerless over crying, as before attending SCAT she felt no control over it and perceived her own tears as a betrayal of private feelings to a public audience that made her vulnerable. The theme of having some control over one's feelings as a goal in SCAT or in life in general seemed to be an important one for some of the children. The idea seems to be not so much the desirability of keeping feelings hidden in general, for most of them articulated the value of expressing them, but to have some control of when, how, and with whom to allow one's feelings to emerge.

Virtually all of the children interviewed have undergone events in their lives that range from chronic stress to traumatic experiences (see Hernandez, 1990). They also fear such events happening, for they always seem close by when their occurrence is so pervasive in their own communities.

Among the fewer than twenty children interviewed, there were ones that had experienced family members or friends being jailed, a drug-addicted mother, an alcoholic aunt, the death of a parent through AIDS, the drug-related death of a brother, the shooting of a close relative, physical or sexual abuse, foster care placement, suicide attempts by close relatives, serious family illness, blatant racism, running away, war, witnessing violence at home or on the street, weapons in school, robbery, drug dealing, and the presence of gangs. What are nice children like them doing in a place like this? They are living their lives, like everyone else, only their lives require perhaps a little more courage, pain, creativity, toughness, and resilience than do the lives of most of the rest of us.

CONCLUSION

Learning from Children's Words

What children in the inner city tell us about their lives and their needs can lead adults to despair; indeed, perhaps it should lead us to a moment of despair. After breathing deeply we can then begin to focus on the task of what we who have

more power in society are to do about their situation. SCAT can use this feedback, these ideas, and these perceptions to inform its programming decisions; others can also listen to urban children's message about our collective society. Maybe they need not keep learning from our mistakes.

LeCroy (1992) stresses the importance of targeting children's environments, including the adults in it, as the objects of change efforts. Children do not, however, need to become or remain passive in this endeavor. They have a lot to say about their own lives, they possess the creativity and strength to devise solutions to difficulties, and they are usually far more willing than adults to work collaboratively to resolve problematic situations. Dubrow and Gabarino (1989) found that the young children living in public housing in Chicago knew what to do and what not to do to minimize their risk of victimization. An eleven-year-old from Boston tells us the same thing:

> The kids down here, they don't go down there, 'cause they know that's where they all <u>be</u> at. And they all just sell their drugs, right there...A lot of kids are aware of where they sell drugs. So they know not to go where and when. Like my little brother: He's three years old, and he knows where not to go and where to go.

One of the roles of programs such as SCAT in the inner city may be simply to be willing to listen to children like this one, to provide support, to validate the unfairness of the situation, to brainstorm about empowering courses of action, and to advocate for things they define as helpful.

Compas (1987) discusses the importance of flexibility in successful coping with stressful life situations, where a person is able to discard one coping strategy in favor of another that is better suited to a specific situation. The creation of a progressively broader repertoire of alternatives within any situation is a strategy that SCAT employs frequently with children and with ourselves as ways of getting "unstuck" in circumstances that seem overwhelming. We also are willing to be with them through the difficulties and to build up their network of others who can also be with them. Gabarino et al. (1992) state that for children who live in chronic danger, the primary role of clinical services is to build on their primary relationships, "...to create a new positive reality for the child that can stand up to the 'natural' conclusions a severely traumatized child is likely to otherwise draw about self-worth, the reliability of adults and their institutions, and safe approaches to adopt towards the world." (p. 378)

Cowen (1991) advocates for stressing people's strengths and competence, rather than "pathology" in order to empower them and to enhance resilience. The combination of building on specific strength and on self-sufficiency in combination with providing the respect, validation, and support with which to do so can create a powerful and power-sharing model for services to children. In order to accomplish this we need to keep the listening channels open and to maintain the mutuality of

the learning process. We may be experts on particular mental health or social service dynamics; the children are experts on their lives.

Directions for the Future

Several of the themes that emerged from this interview venture could well merit a follow-up study of their own. Of particular interest would be further exploration of children's friendships and the role of gender in this, of the development of trust for inner-city children, of resilience, of children's creativity within adverse life circumstances, of competence correlates of racial and multicultural identity, and of more in-depth evaluation of program components.

We have learned something, through these interviews and observations, about children's views of one program, their perceptions of certain events and relationships in their lives, and their strengths. What has also become apparent is the broad range of program aspects that can make a difference: the professionals' favorite, "talking" therapy; a variety of activities that seem to serve the purpose of distracting children from pain, creating a sense of cohesion or belonging, and providing fun experiences; and the mere presence of such a program in a school. Through their words and their actions, the children are telling us something. As one nine-year-old said, the SCAT program is a good thing because it can help to "make things happier." It is difficult to ask for a more compelling vote of confidence to keep plodding on our way to attempting to build an increasingly effective and useful program.

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OVERCOMING MYTHS, ABUSES, and ATTITUDINAL BARRIERS CONCERNING LEISURE SATISFACTION REGARDING ELDERLY, DISABLED, and MENTALLY ILL

Gerald Cardoza

This paper reviews and discusses myths, abuses, and attitudinal barriers concerning leisure satisfaction for the elderly, disabled, and mentally ill. We will present some problems facing this special population, possible solutions, and future needs with the role that recreators will play.

For the purpose of discussion and avoiding duplication, we will prepare this paper using the terms aged or elderly to represent the disabled, and mentally ill recognizing that common similarities exist in all groups.

Our principle concern is leisure satisfaction that meets the needs and interest of the elderly population. We will try to discuss problems facing the older population, possible solutions, and future considerations.

During the last century older citizens have increased dramatically. It is projected that by the year of 2000 there will be over 30 million persons over 65, about 12 percent of the population.

Unfortunately, increased age is often equated with increased illness and decreased well being. Older persons make 50% more doctor's visits than adults under 45. The hospitalization ratio is three times that of young people. To a large extent, the elderly have been excluded from the fitness/wellness movement which suggests that we have got to do a better job of prevention and management of health care concerns for the aging society.

Although now afforded increased time for activities, many elderly persons have substantial psychological barriers to enjoyment of leisure. In addition to feelings of guilt, internal or external, over being nonproductive, they are affected by the lack of role definition for their new found leisure. In short, the elderly have learned neither to enjoy nor value leisure. There is now large amounts of time to fill. The potential for leisure counseling with older persons appears both obvious and enormous.

Counselors who work with today's elderly need to understand that this lack of leisure participation is likely dependent upon several psychological factors such as leisure attitude, motives, needs, perception of personal freedoms, control personality traits as well as lack of skills, all of which relate to leisure satisfaction and participation.

To understand the enormous problem facing the elderly, disabled, and mentally ill, let us first ask the question; What do you do in your leisure time? It most likely depends on several factors. You may work off your tensions with a five mile jog or a quick set of tennis. Come weekend you might pack a lunch and head for the beach, fun and exercise with the family. Leisure, as you can see, demands a pretty flexible, hassle-free schedule.

Now imagine being elderly, disabled, or mentally ill and confined to a wheelchair. Would that affect the things you want to do, or when you wanted to do them? You can be sure that your pursuit of leisure would neither be flexible nor hassle-free.

A day in a wheelchair can be frustrating. Where would you go? Does the wheelchair pass curbs? Do you have to flag down pedestrians to help you up and down sidewalks? What about when your children begin to participate in activities?

Initially, you may not think so but you soon learn that most things you want to do with your leisure time are difficult or impossible by a variety of barriers, physical or otherwise. You are handicapped, dependent, and different. Do you begin to slowly feel society's attitudes toward the elderly, disabled, and mentally ill?

Can you see that you may/might lower your expectations concerning leisure outlets for your needs? Do you see yourself over a period of years becoming passive and withdrawn? If this is beginning to scare you, then you are grasping a little of the grim implications of living in a world designed for the able-bodied norm. The aged, disabled, and mentally ill, contrary to belief, have the same needs and right to use the broad leisure experiences that meet their ever changing leisure time objectives.

A great deal can be done to begin accommodating the clients' range of needs through creative programming and simple access. Solutions lie within those in power to control allocation of resources and professionals mandated to provide recreation for everyone.

Many myths are attached to aging, the neglected step-child of the human life cycle. It is easier to manage the problem of death than the problems of aging. Death is a one time crisis while aging is day to day, year by year, constant confrontation with internal and external forces. Let,s look at some of the myths attached to aging.

Myth of Age

The idea of chronological aging is a myth. Its quite clear that there's a great difference in rate of chronological, physiological, and psychological aging from person to person. Older persons actually become more diverse rather than similar with advancing age.

Myth of Unproductivity

Many believe the old are unproductive. In the absence of diseases, old people remain active and productively involved with a substantial number becoming unusually creative for the first time, continuing to contribute usefully in a variety of ways.

Myth of Disengagement

Old people tend to disengage from life, to withdraw themselves, choosing to live alone or with their peers. Aged persons mutually separate from society as a part of the aging process. Disengagement is one of the many patterns relating to old age.

Myth of Inflexibility

The ability to change and adapt has little to do with age. Most if not all people change and remain open to change throughout life. Change is part of living. One tends to become more conservative out of economic necessity rather than out of qualities innate to the psyche. Conservatives do exist among the elderly but so do liberals, moderates, and radicals.

Myth of Senility

Senility is a popular layman's term used by doctors to categorize the behavior of the old. Anxiety and depression are frequently lumped within the same category of senility, even though they are treatable and reversible. It is easy to blame age when accounting for mental illness. Drug tranquilization, malnutrition, unrecognized physical illnesses, alcoholism, heart failure and bereavement can produce senile behavior.

All of the above if improper and inaccurately diagnosed could label the elderly as senile. Depression is widespread in late life with grief as a frequent companion of old age through one's losses.

Anxiety is another common problem generally associated with poverty, loneliness, and illness.

All of the above myths and stereotypes can be explained in part to lack of knowledge and profound prejudices against the elderly. The reality is that the productive minded society has little use for non-producers. Avoiding for the time being reminders of the personal reality of our own aging and death.

Elderly Abuses

Elderly abuse, as shocking as it sounds, is being heard about more frequently. Child abuse was <u>discovered</u> in the 60's; spouse abuse in the 70's; now elderly abuse in the 80's and 90's.

Caretakers for the elderly are under both informal and formal categories. Informal being family members, neighbors, and friends. Formal are those found in institutional settings.

Neglect and abuse vary with the elderly depending on the caretaker for basic needs. Often family members hastily agree to care for relatives without being cognizant of the realities. The responsibilities may be too much with role reversal and power struggles arising.

Society's prejudicial attitudes toward the elderly are often causes for abuse and neglect. The individual may experience more than one form of abuse. Drug and nutritional neglect may manifest itself by confusion, malnutrition, abrasion, lacerations, sprains, fractures, burns, over sedation or other types.

Most abuse by family members isn't premeditated, but more crisis precipitated. This abuse is often repetitive with small annoyances now exaggerated and blown out of proportion.

Formal caretakers are known to administer large doses of tranquilizers to the elderly for the purpose of making them manageable.

Over 50% of the nursing home population are given tranquilizers on a daily basis, even though 90% have never been diagnosed as having psychological problems.

Nutritional depravation has been known to cause a variety of symptoms with the elderly that are life threatening manifested through anxiety, apathy, delusions, fatigue, loss of memory, and insomnia. These symptoms are often diagnosed as senility dementia or depression. What is the remedy? **DRUGS**

Financial and neglect or other abuses are found frequently. In an informal setting, general mismanagement of funds, property, and other assets including outright theft are common. In a formal setting, nursing homes hold trust accounts, failing to enter receipts or note false disbursements with improper charges and services.

Psychological abuse occurs in all forms, manifesting itself in any manner that causes degradation. Verbal assaults and neglect often promote regressive traits and intensify feelings of helplessness, undermining any remaining sense of power and dignity.

Fear is one of the reasons that the abused do not report incidents, fearing retaliation, feeling defeated, depressed, and apathetic, often ashamed and embarrassed that children are responsible, thus avoiding publicity.

Prevention of abuse is imperative for professionals who come in contact with the elderly, becoming educated regarding early telltale signs of abuse, even the not so obvious. Look for various behavioral oddities displayed by the elderly (fear).

Everyone should view elderly abuse realistically, honestly, and assume responsibility for alleviating its cruelties.

Realities of the Elderly Population

The elderly are becoming a larger and more influential element in the American society. With the increased life expectancy, government officials are becoming more sensitive to their voting strength and political influences. Just focusing on the frail elderly, those in nursing homes, the impoverished and mentally ill, is a serious misconception. The elderly have many differing characteristics. They are not a homogeneous group despite similarities in age.

Older persons continue to be the most economically deprived with Black, Spanish speaking, and older women not living with family, the most impoverished. Many are left without a clear understanding and knowledge of leisure and how it manifests itself during the life cycle.

The term leisure has had many meanings in gerontology literature. Leisure for our purpose is a state of mind. It is considered the highest form of activity of which the activity is performed for its sake or as an end in itself.

The concept of perceived freedom is a dimension of leisure along with intrinsic and extrinsic motivation giving satisfaction as a consequence for engaging in an activity.

Leisure satisfaction should not lead one to believe that satisfaction is achieved in all cases through active leisure participation. Individual differences must be considered to allow continuity and change.

Elderly were cared for along with the sick, mentally ill, destitute and criminal in undifferentiated institutions. The institutionalization of the aged is viewed as a penalty for improvident or dissolute life. This attitude continues today, contributing to the stigma attached to residence in institution.

Isolation of the Aged

Isolation of the aged and infirm continue to be the predominant social policy. The term institution usually refers to "care provided for in an institutional setting over an extended period of time." Extended care facilities are short term convalescent care facilities specifically arranged to take care of carefully selected patients from hospitals. Nursing homes are institutions that provide care for the severely ill patients. Intermediate care facilities are designed to provide health supervision with access to health services without full time professional staff.

Nursing homes have been increasingly used as care centers for the aged, disabled, and chronically mentally ill. This shift in population of nursing homes has resulted in their care becoming more for the medically and mentally impaired older persons. We must avoid the return to total institutional warehousing with little effort in providing life sustaining social supports.

There must be an avoidance of older individuals being increasingly shaped by the environment rather than shaping the environment to meet the individual's needs. This new environment should encourage outside integration with the community, social integration and decision making.

Traditional Treatment

The traditional approach to treatment of the elderly, disabled, and mentally ill was to look at the problem not the person. The procedure was to label an individual, place them into a categorical program, then plan a program. The resulting program had little to do with the individual's needs, abilities and interest.

A most unfortunate effect of persons with disabilities and mental illness is the tendency to group them by their diagnosed disability or the degree of mobility. This was done for the purpose of efficiency. Social grouping done on these lines has proven to be inefficient, inappropriate, ineffective, and artificial. Other than their common ailment, clients have no other natural interest to base the social relationship on.

An alternative to this traditional approach avoids assumptions about people based on labels. The client's problem is not an exclusive personal characteristic, but a result of the interaction of individual differences with the environment. The focus should be on the individual, their abilities, interests, and limitations, the total person. This enables us to avoid restrictive dimensions of the traditional view.

Possible Solutions to Meeting the Aged, Disabled, and Mentally Ill's Needs for Leisure Satisfaction and Participation

Leisure professionals have operated in somewhat of an antiquated system of services with the power exclusively in the hands of the caretaker. We have been

exposed exclusively to the theory of a split between the mind, body, and spirit. This view holds the belief that living organisms are constructed of separate parts. The leisure field has mirrored this attitude, emphasizing traditional separation with special emphasis on work, family, religion, and leisure. Leisure is now linked with time, justification, and responsible behavior. Much of this is built on misinformed power, antiquated knowledge on things that don't work. Leisure offers much more, with excellent opportunities to perceive accurately a shift in basis of care, both philosophical and practical.

We begin by giving to relationships an integration of the body, mind, and spirit. Integrated wholes have been properties that cannot be broken down into smaller units by operating on the principle of self organization (empowerment), everything is always operating together. A theoretical concept that recognizes the continuous blend of the mind, body, and spirit within all aspects of our lifestyles. The range of expression suggests that we are all engaged in some form of self-renewal and self-transcendence.

Leisure as well as other helping services are in a fragile position of relinquishing their control over clients. We need to realize that promoting programs and services that mimic the passive-dependent consumer role need to change. Therapists are regulators of leisure experience through subtle forms of power, manipulative types of experiences:

Consumer's Ultimate Goal is to Maximize Functioning in:

1. Addressing living needs
2. Increasing socialization
3. Stimulate cognitive functioning
4. Enhance quality of life
5. Encourage appropriate behavior
6. Adapting to environment
7. Access patients to their strengths
8. Stimulate vocalization and interaction
9. Promote self-esteem
10. Increase opportunities for enjoyment

Rehabilitative Programs Designed to Provide Leisure Satisfaction

Reality Orientation was introduced around 1958 and found to alleviate manifested confusion and disorientation. Leisure service personnel can implement many reality orientation approaches in their program. The program leader can orientate the group as to time, date, and describe the program using large monthly calendars as props to assist in reality orientation.

Remotivation, another program, designed to bring the individual to a higher level of functioning. Remotivation can be incorporated into a variety of leisure

programs. Example, during music appreciation, members could be introduced to discussions of the composers and assist in planning the next musical program.

Reminiscence was long thought of as an indicator of loss of memory. It is now thought of as a normal life's review and a healthy preparation to the last phase of the life cycle. Often life's experiences serve as a mechanism that enables past experiences to return to the consciousness with deeply buried conflicts resolved.

Leisure service specialists can easily incorporate reminiscence into leisure programs. For example, do arts and pictures illustrating different life events.

Leisure personnel are essential to establishing an environment for rehabilitation and maintenance of the elderly. A primary purpose of leisure service is to create opportunities and reasons for persons affected by conditions that require long term care to exercise abilities and continue life's tasks which were previously taken for granted that will maximize and reinforce independence.

Designing programs to meet the leisure needs, interest, and demands of the elderly in the future requires an examination of what they will be like. Older persons of the future will be different because of different histories and events that have shaped their lives. Leisure services must therefore be shaped by the nature of the elderly they service.

Forecasting the characteristics of future older persons must take place if leisure services are to be rationally planned. Social forecasting for future elderly persons is vital if choices are to be made. In as much as humans are social beings, with the elderly losing social partners more frequently then younger person, the need for social interaction among the elderly is most important. This should be the starting point in planning activities for older persons while respecting their need for personal responsibility, choice and control over their lives. Nurses and therapists constitute the main source of patients social interaction responding to their personal desires rather than staff imposed. Once a program is established it should not be disrupted, even with staff changes.

The population of older persons will become a larger and more influential element in the future society. Characteristics to examine include numbers, percentage, life expectancy, health, socioeconomic status, minority groups, residence, living arrangement, political power, activism, and leisure.

Future leisure environments of the elderly will be built on the foundation of increasing societal respect for old age. The increasing social status has been assisted by growing prosperity of older persons resulting from gains in educational and occupational status. The development of the future leisure environment of the elderly may well become the dominant option for older persons along with the needs for food, shelter, and health.

Recreational therapists should strive intentionally and actively to remove the psychological barriers which prevent clients from experiencing satisfactory leisure and recreation. Clients need to perceive control, avoiding helplessness. Recreational activities should be used as a treatment modality. One could say that there is a strong bias to call a healthy person sick rather than a sick person healthy. This tendency often involves personal and social stigmas which have lasting psychological consequences. Therapists must believe in their client's capacity to function.

Quite sadly, the nursing homes are now the warehouses with services to the needy by the greedy. Patients' welfare is of trivial concern to those who run the nursing home industry, profiteering, perjury, and kickbacks are common. Free enterprise now has made taking care of the elderly big business.

In light of the above described state of nursing homes, it becomes urgent to take action correcting the problem and restoring human dignity. Therapeutic Recreation can play a major role. First, staff need to be aware that they are fostering helplessness. Second, adapt a philosophy directed toward maximizing human dignity through individualized treatment. We must strive to enhance the patient's personal responsibility and increase freedom of control, thus, guaranteeing their psychological well-being. Leisure must not be analyzed as an isolated aspect of life. It is an interdependent element of the total human behavior.

In summary, we have discussed barriers toward leisure satisfaction for the elderly, disabled, and mentally ill without any agreed method of solution. To be effective in improving the quality of life for the elderly, staff need to increase their knowledge, create positive attitudes, encourage participants to develop skills, and empower older persons with a sense of ownership in their programs and outcomes.

Freedom remains leisure's precondition, its reward being freedom, and can relate best in pursuits that are leisurely. Leisure undoubtedly is the most precious and most fragile expression of our freedom.

A major fight to be won in the immediate future is the dissipation of man's illusion that his own welfare can be separate from others.

CASE STUDY COMPARISON OF TWO BILINGUAL INDIVIDUALS

by

Denise Carr-DeRamus, CAGS/LMHC

John Ogbu developed a theory in his article "Understanding Sociocultural Factors: Knowledge, Identity, and School Adjustment" that addressed differences between people of differing minority status. He classified people into three groups holding minority status. The first group is "autonomous" minorities. In the United States, these are minorities in numbers and are not necessarily discriminated against in a stratified system. Members of such a group in the United States may be religious minorities.

The next group is immigrant minorities. These people have moved voluntarily to their country for religious, political or economic reasons. Although this group may be discriminated against, they do not always accept the status given them by the dominant culture because they compare their situation to their homeland as a frame of reference. They may not understand the culture that they moved to, therefore, may not buy into the negative image that could be afforded them. Immigrants often compare themselves and measure standards based on their own group. Often their motivation for coming to the United States is to advance themselves and their children and they take advantage of those things that they perceive to better enhance their lifestyle. Immigrants often have the option to move back to their homeland or elsewhere if they do not find the country to which they moved to be acceptable.

The third group that Ogbu identifies is the caste-like minority who have been incorporated involuntarily in a society through "slavery, conquest, or colonization and then relegated to menial status" (Ogbu, 1978). Membership in this group tends to be permanent. This group is also discriminated against and exploited by the dominant group, but their response may be different from that of immigrants. Discrimination often takes the form of unequal education and job ceilings that make it difficult for members of a caste-like minority group to advance. Members of these groups are often scapegoated by the dominant society who attribute traits to the group that they themselves do not like. Although members of the caste-like minority groups do not accept the dominant culture's view of them, they often develop alternative strategies for survival in the belief that they may not be able to succeed in mainstream society.

"Castelike minorities tend to form a sense of peoplehood or collective social identity in opposition to the collective social identity of the dominant group" (Ogbu, 1978). As a means of protecting this social identity, an opposing culture to the

mainstream culture may be formed such as differing language and communication styles and rejection of Anglo behavior and preference.

Immigrants tend to have a style of Primary Cultural Differences in which 1) the differences existed before the minorities came in contact with the dominant group; 2) the cultural differences are quite specific in nature and are usually a matter of content; 3) the minorities recognize the differences and the problems they generate in school and the workplace, and they are usually willing to learn how to overcome the cultural discontinuities in order to succeed; and 4) immigrants do not suffer from emotional crisis and ambivalence when they try to learn the cultural feature of the dominant group they need to know in order to participate effectively in school and in the workplace. Caste-like minorities develop Secondary Cultural Differences that 1) arose after the minorities had been subordinated by the dominant group and 2) are more a matter of style than content; 3) bearers of secondary cultural differences are reluctant to accept or learn certain features of dominant group culture as well as some behavioral norms, assumptions, and practices in the institutions controlled by the dominant group; 4) in school, bearers of secondary cultural differences may not only refuse to cross cultural boundaries, they may also organize themselves in opposition against the teacher. Finally, those individuals who try to cross cultural boundaries may experience both affective dissonance and social identity crisis and negative peer pressure to conform" (Ogbu).

I would like to follow with two case histories of a Bilingual Cape Verdean immigrant and a Bilingual Puerto Rican who would be considered a member of the caste-like minority group ascribed to by John Ogbu.

CASE STUDY - MANNY - CAPE VERDEAN

Cape Verdeans in Cape Verde:

The Cape Verde Islands were a Portuguese dependency until July 7, 1975. The Islands were uninhabited until the advent of the slave trade in which Africans were brought to the Islands as workers and wives of the Portuguese settlers. Seventy-eight percent of the Island population is Mulatto. The island of San Tiago is a seventeenth century slave emporium and houses most of the twenty percent African population. "Whites" comprise two percent of the Island population.

On the Islands, Cape Verdean Crioulo is the spoken language. It is not a written language. Portuguese settlers attempted to forbid Crioulo to be spoken, although the residents of Cape Verde continued to use the language of the community. The official language of Cape Verde is Portuguese, and it is Portuguese that is used in all formal settings. There is a political movement afoot on the Islands to make Crioulo the official language. One of the difficulties is that Cape Verdean Crioulo varies from island to island.

Cape Verdeans were distributed on the socio-economic scale based on skin color. The darker a person's complexion was, the poorer they were and the less likely to emigrate. Immigration from the Cape Verde Islands to the United States began in the first half of the nineteenth century when young men were recruited to work on whaling vessels. Cape Verdeans were recruited primarily because they accepted low wages. They saw the wages they received as higher than they could make in their home country. While working on the whaling vessels, Cape Verdeans were discriminated against due to race and ethnicity. Yet, some Cape Verdeans returned to the Islands from the United States to buy land and businesses after emigrating, bringing Blacks and Mulattos to prominence in the Islands.

<u>Cape Verdeans in the United States</u>:

Many Cape Verdean Americans were from the island of Brava, or had emigrated through that island. Therefore, Cape Verdean Americans were sometimes called Brava. Sixty-one percent of emigrees to the United States were from Bravo or Fogo. The next largest group of emigrees came from San Tiago. It is difficult to obtain the actual number of Cape Verdean Americans in the United States before 1975. They were counted as Portuguese on the government census.

Many Cape Verdeans settled in New Bedford and sent back to the Islands for family members. Here, they continued to nurture their culture. Cape Verdeans depended on group identity and self-help to survive. This system remains in place to this day. They live in communities, primarily in southern New England, "bound by language, custom, behavior, diet, and religion" (Carreira, 1982). Women were brought from the Islands to the United States because there was an abundance of men in the Cape Verdean communities in America.

Cape Verdean immigrants continued to work in the whaling industry, as well as factories, cranberry bogs, and as gardeners. Some migrated to California and worked as farmers, ranchers, gardeners and railroad help. When the whaling era ended, Cape Verdean sailors began providing sea transportation between New Bedford, Providence, and the Islands. Thus, they had control over their own passage to the United States.

As stated before, Cape Verdeans were discriminated against while working on the whalers due to race and ethnicity. The racial discrimination that they experienced on the whalers was a precursor to the discrimination that they would face when they arrived in the United States. The whaling ships resulted in communities of Cape Verdeans in Southern New England, Hawaii, and California.

Later, in the nineteenth century, cranberries became an important crop in the United States. Other ethnic groups harvested the crop, but by 1910 Cape Verdeans dominated as cranberry harvesters. New arrivals could make enough money during a busy season to survive through the winter, send money back to their families in Cape Verde to eat, buy land, or buy businesses. The money could also be used to

bring other family members to the United States. The tradition of working during the summer, sending money back to relatives in the Islands, and bringing relatives to the United States continues.

Before 1920, Cape Verdeans entered the United States freely. In 1965, Cape Verdeans were restricted by the immigration law because they were a dependent of a foreign country. After independence in 1975, the immigration law allowed the number of Cape Verdean immigrants to increase dramatically. Portuguese immigrants began to ostracize Cape Verdeans in this country based on skin color due to the nature of racism within the United States and feared that they would be considered non-White and would themselves become victims of racial discrimination.

Cape Verdeans in Massachusetts:

Due to the ostracization of Cape Verdeans by the Portuguese, Fall River established a special Catholic mission since Catholicism was the predominant religion for both Portuguese and Cape Verdean immigrants. In keeping with the tradition of the Islands, Portuguese remained the formal language of the church services.

In the 1950's, some Cape Verdeans moved to Boston within the African-American community. As was the case in Fall River, a special Catholic mission was established for them in 1970 at St. Patrick's Church in Roxbury. This occurred because the majority of Cape Verdeans were Catholic and the majority of the African-American community is Protestant.

In 1971, Cape Verdean families began to insist that their children be taught in Portuguese through the Transitional Bilingual Education Act. The demand for these classes typify the strong Cape Verdean interest in education, although most attended schools within their own community rather than travel away from their families. After Cape Verde gained its independence in 1975, Cape Verdean American parents got Massachusetts to recognize Cape Verdean Crioulo as a language and Cape Verdean bilingual programs came into being.

There is a split in the Cape Verdean community between the older generation of Cape Verdeans and the younger generation. The older generation did not choose to identify with African-Americans. They perceived their culture to be closer to Portuguese. They did not identify with the slave experience that African-Americans endured and their religion was different from African-Americans. They also felt that identification with African-Americans would limit their upward mobility which was already hindered by a language barrier.

Joining with the African-American culture appeals more to the younger generation of Cape Verdeans, although they show more interest in seeing themselves as a separate ethnic group, neither African-American, Spanish-

surnamed, or Portuguese, although they maintain a minority status. Both groups of Cape Verdeans continue to maintain the basic tenets of their culture - food, language, holidays, and group preservation as evidenced by dances and parties given to assist ill members of the community and those in other kinds of trouble. Both groups still send money, food, and clothes back to the Islands and send for relatives who wish to come to this country.

Case Study:

Manny is a twenty-one year old Cape Verdean man who attends a local university on a full scholarship. He is an extremely intelligent man who is well-rounded, participating in athletics and extracurricular activities as well as excelling in his academic work in both high school and college. He has received many awards for his achievements in both spheres.

Manny was born on January 22, 1970, in San Tiago, Cape Verde. He was the second oldest of four siblings, three brothers and one sister who is the youngest. He comes from a close family who emigrated to this country six years ago when Manny was fifteen years old. All family members continue to reside in their parents' home and all have gone on, or plan to go on to higher education. This is due to the high value that his family places on education.

Manny states that all of his father's family was born in Brava, Cape Verde, and his father's parents are also from Brava. His paternal grandfather is a carpenter. His grandfather has been a role model in Manny's life due to the cultural aspect of the oldest living male being the Patriarch. In addition, his grandfather's strong interest in Cape Verdean literature and poetry has had a positive impact on Manny. His grandfather never went past the sixth grade and was described as "a self-made man." Manny's grandfather is a carpenter and is presently retired. Manny's paternal grandparents currently live in Rhode Island. Manny's father has twelve siblings and he is the sixth child. Manny's father was a licensed nurse in Cape Verde. He currently works in a factory in the United States.

Manny's mother was born in San Tiago, Cape Verde. Her mother was born in Fogo and her father was born in Guinea Bissau. None of Manny's grandparents had a formal education beyond the sixth grade. All are literate in Portuguese. His mother finished high school in Cape Verde. She did not have to work and was able to hire someone to take care of her children. Manny's mother currently works in a factory. Her mother continues to reside in Cape Verde and supports herself by sewing. Manny says that he did not know his maternal grandfather because he was killed in the war in Guinea Bissau.

Manny states that his parents were his most significant role models in childhood and that they instilled ideals in him. He saw his uncle as a role model.

Educational Experience:

Manny states that his elementary school in Cape Verde was free and was co-educational. He states that schools in Cape Verde require spoken Portuguese from kindergarten. This is the official language of the Cape Verdean Islands and is spoken in all formal situations. Children are required to take French and English in school by eleven years of age. Both within the family and in the community, Crioulo is the spoken language. Manny completed eighth grade in Cape Verde.

When Manny came to the United States, he was sent back to junior high school due to his lack of command of the English language. He entered the Portuguese Bilingual Program for one and one-half years. Manny stated that he felt "helpless to change the situation" of being placed in a lower grade then he would have been if he remained in Cape Verde. He recalls that his father became angry at him because his father did not understand why his son was being placed in a lower grade and perceived this as academic failure in his son. Manny recalls that he had some difficulty making friends with American children due to the language barrier. Therefore, most of his friends in junior high school were Portuguese and Cape Verdean.

Manny went on to a Bilingual High School Program in which there were two hundred fifty Cape Verdean and Portuguese students. Manny studied French to fulfill a language requirement, although he is not fluent in French and does not practice it. Manny states that he also studied Spanish for one year and finds it helpful in communicating with people. Manny states that he found his knowledge of Spanish particularly helpful when he came to the United States due to the large Spanish speaking population and the similarities between the Spanish and Portuguese languages.

The languages that Manny is fluent in are Crioulo, Portuguese, Spanish, and English. He says that he prefers speaking Crioulo since it is his native language and he feels most comfortable with this language when he is speaking. It is the language that he uses to communicate with his parents and his roommate. Manny is careful not to use English or Portuguese when he is with relatives or Cape Verdean friends because they will feel that he is showing off because he went to college.

Manny says that he found the bilingual programs that he attended helpful. They served as a support for him and provided him with a way to process his feelings of culture shock with people who were also sharing the same type of experiences. Manny graduated from high school as valedictorian and states that he saw his guidance counselor as a role model.

At home, Manny translates for his parents, since he says that he believes that it was more difficult for them to learn English than for him and his siblings. It speaks of his respect for family that this does not cause any disruption to the family

hierarchy. He states that his parents understand English, but they are uncomfortable speaking English for fear of making mistakes.

It is also clear that Manny maintains a high degree of pride in his ethnic background. He states that he prefers to speak Crioulo when given the opportunity, but sees being bilingual as an advantage in studying other cultures. He speaks Crioulo in the Cape Verdean community when he is having difficulty expressing himself and when he wants to speak privately in the presence of English speakers. He also uses Spanish on occasion.

CASE STUDY - JUAN - PUERTO RICAN

Bilingualism has been a factor in this country since its inception, yet bilingualism found its most widespread acceptance in the United States around the period just prior to World War II. This was particularly true within German immigrant communities in which schools were taught in the German language and German culture was valued. In the advent of World War II, there was less tolerance of bilingualism and English became the mandated language of education. To speak a language other than English was perceived to be unpatriotic.

Since the 1960's, there has been a drive to return to tolerance, if not full acceptance toward bilingualism, but the emphasis is placed on assimilation into the wider, English speaking community. Yet, with the advent of more Spanish speakers living within the United States and the prediction that by the year 2020 the school system in the United States will be more than fifty percent language minority students, it is seen by some as preferable that more culture-specific practices come into place, to include bilingualism. Still, there are some advocates of English becoming the official language of the United States in what seems to be a backlash attempt to ward off the influx of language minority groups coming to the United States at this time.

Since language and culture are found at the core of one's identity, it should not come as a surprise that factors such as politics, economics, race, religion, and self-concept will distinguish in what ways a particular minority language will be viewed, both by the dominant culture and by each other.

Attitudes Toward Bilingualism Within the United States:

Within the global community, some people perceive monolingualism as being the only desirable state. Others see multilingualism as being the only desirable state. Yet, there is a whole array of attitudes between these two spectrums. Most European colonized countries lean toward monolingualism in the direction of the language of the colonizers. The United States is one such country. "In the United States, growing up bilingual was a reason for discrimination. Being bilingual has ... in the United States ... been used almost as a synonym for being poor, stupid, and

uneducated .... Interactions between educators ... minorities ... and the community ... reflect the power structure in the wider society where minority communities are disempowered" (Skutnabb-Kangas & Cummins; 1988; p. 2).

Additionally, in the United States, attitudes toward bilinguals depended on the "political and social status of a particular language minority group" (Skutnabb-Kangas & Cummins; p. 48). If a group was not favored, their language would be devalued and legislation would be instated to take the rights of the language minority group away. Attempts to curb voting practices were linked to English literacy requirements. From the Second World War until the 1960's, English was the language used for education. Even today, the goal of bilingual education in the United States is to assimilate language minorities into the mainstream culture. It is also no surprise that English language proficiency in the United States is linked to upward mobility. Therefore, there is strong motivation for people to learn a second language. Juan says that he thinks English speaking people are disrespectful, although this is a trait he reserves to describe Spanish speaking people most often. It is interesting that since Juan moved to Massachusetts he has been married to two Caucasian women.

Juan has accepted many Anglo values and attitudes, although his English language carries much of the vocabulary of the African-American community. He has been heard making racist comments when he felt left out of a situation. When he was confronted, he said that he would not be offended if someone made racist comments about Spanish people because "they would be expressing their feelings." This comment occurred after years of traditional psychotherapy provided in the institution in which he resides. He also expressed the disbelief on more than one occasion that being taught by his parents not to make eye contact was somehow wrong - again, after many years of contact with Anglo therapists who stress eye contact.

Juan speaks English within the institution because he opts to spend most of his time with English speakers. He does speak Spanish to Spanish speakers in the institution. He expressed that he feels that Spanish speaking patients "disrespect" others by speaking Spanish in their presence when other people do not know the content of the conversation.

Juan was sometimes asked to interpret for other patients in the institution. He says that he felt uncomfortable doing this because he was relaying their private information to the staff, a task that would be difficult for anyone in a prison-like environment, although he did express some pride that he was able to provide this service. He continues to work for staff in almost any way that he is requested.

Juan also uses his language barrier to "get over" in the institution. He says that he would ask people if he could do things that he would otherwise not be allowed to do. Since they were unable to understand him, they would say "yes." Yet he sometimes experiences that same difficulty when people use words that he does
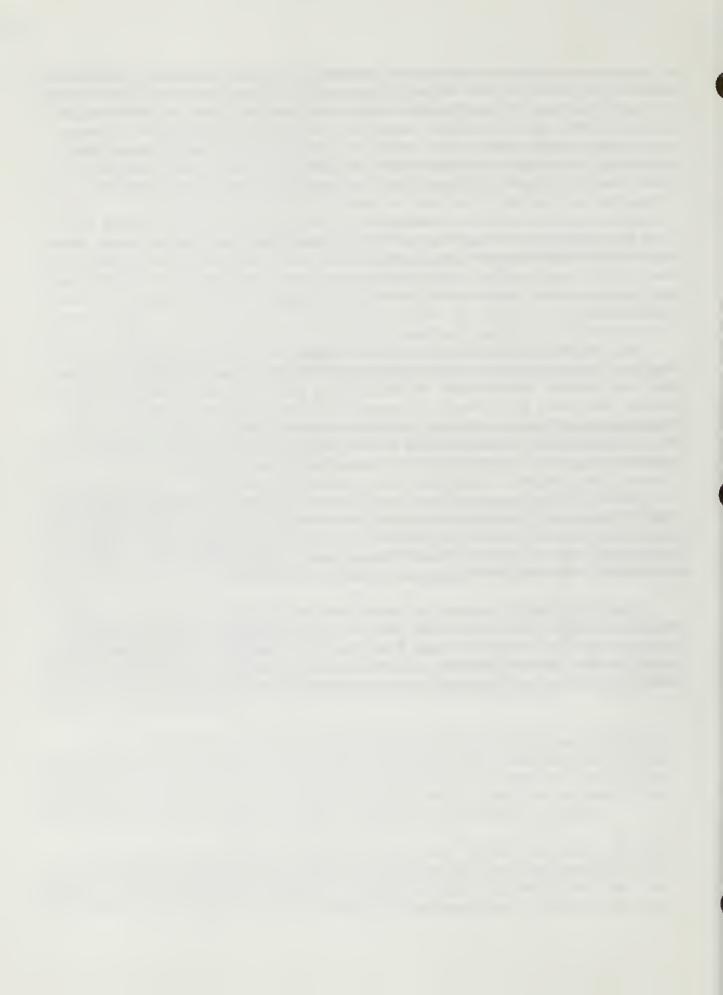
not know. He says that he does not ask because he is afraid that people will think that he is a "dumb Puerto Rican." Therefore, he sometimes finds himself in awkward situations, because he was afraid to ask what was said. A recent positive change has been that he has been asking that words be explained more in groups. Yet, the more negative traits described above, along with his incorporation of Anglo values and marrying Caucasian women because they are "nicer" than Spanish women, would lead one to believe that his self-esteem might still not be intact.

Juan says that he does not want to forget his Spanish and reads Spanish books in his room. He also says that he practices speaking Spanish as often as he can. Juan is of the belief that to lose language is to lose both your culture and your identity. He does say that he feels that it is good to know two languages or more, and that bilingual education is important for learning language and keeping a person's culture alive.

Juan does say that he has difficulty reading and writing English because "English is not important to me." This limitation has created problems for him. After ten years of incarceration at this facility, Juan requested that the Clinical Director help him go through his records. They found documents that Juan disagreed with. He had never seen his records prior to this because he did not know how to read English. He says that he would like to read, but when he reads books written in English, he bypasses words and loses the gist of the story.

Juan says that he would like to send his own children to a bilingual program when he has them. His priorities would be to teach them Spanish language and culture first, then English language and the culture of the United States. He states that he feels that "it is too late" for him to learn to read English. He refuses to participate in any educational program within the institution.

Juan has recently contacted his father after thirty years. He says that since his reunion with his father, he would like to return to Puerto Rico to share the knowledge that he has gained while living in the United States. Juan is one of the people that is of the opinion that his first language symbolizes home, family, and warmth, and his second language is of use only for survival purposes.

THE ROLE OF THE FAMILY IN FOSTERING RESILIENCY

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INTRODUCTION

The growing influence of family systems theory has resulted in a concomitant concern about how the family can contribute to enhancing positive development and resiliency in children. Increasing urbanization may jeopardize the significance and supportive role that the extended family structure can continue to play in people's lives as it moves towards a nuclear structure and calls into question whether we may have to look at ways to organize people that do not limit us to nuclear units (Jack, 1978).

The objective of this paper is to examine how the family can act as a buffer for children in stressful environments. This does not exclude the role of other factors in the individual and environment that can promote resiliency, after all, there are some children who came from good homes who develop problems, but rather that the emotional climate of the family is one of the important factors to consider in preventive psychology. Protective families can provide a resistance and immunity to the many stressors encountered in daily living.

More specifically, this paper will focus on the Black child growing up in an urban environment under economically deprived
conditions of poverty, overcrowding, alcoholism and substance abuse, minimal access to health care, and poor schooling.

The first part of the paper will be a discussion of resiliency and why it is a useful area of research. Secondly, an exploration of racism and its effects, since a discussion of economic impoverishment includes a discussion of the political system that perpetuates it. Thirdly, an overview of the Black family and its constitution. Fourthly, empirical evidence and what it reveals about how families can increase resiliency in children. Finally, a conclusion that offers a direction for future research.

BACKGROUND TO THE STUDY OF RESILIENCY

Psychology has had a history of making deductions about normal human development through studying abnormal populations. For example Freud's psychoanalytic theory was largely inspired by his interactions with patients who were diagnosed as suffering from the symptoms of Hysteria.

Resiliency research can be used to conceptualize those factors which can help reduce risk. The knowledge gained through the study of resilience holds the key for "inoculating" others to withstand crises (Felsman, 1989) and is a trend away from the disease model, towards one that focuses on the healthy aspects of survival and adaptation. Studying healthy adaptation is a more productive and positive step since it can help in the conceptualization of those factors which reduce risk.

Demos (1989) comprehensively defines resiliency as the capacity to bounce back and recover from obstacles, a complex, psychic organization that waxes and wanes in response to contextual variables. Racist environments are the kind of challenging environments that can debilitate a child's efforts of adapting.

RACISM

Racism defined as a "system of advantage based on race," (Wellman, 1977) is a pervasive aspect of socialization in the U.S. (Tatum, 1992). To capture the psychological consequences of racial injustice Abraham Kardiner and Lionel Oversey (1951) described Black children as carrying "the mark of oppression". More recently, Ogbu and Fordham (1986) have described Black children as "caste-like minorities", which they define as those "who were involuntarily and permanently incorporated into American society by slavery and conquest".

The 1960's saw the dismantling of racially divisive laws in the U.S. At that point, discrimination against people of color was supposed to be eradicated, but what actually happened was that it became informalized. The recent riots in South Central L.A. in May 1992 is illustrative of the subtle form of racism still prevalent in the U.S.

The "at risk" status of Black children compared to their White counterparts is best illustrated by the following statistics: child poverty rates were 45.1% for Blacks compared to 15% for Whites in 1987: infant mortality rate for Blacks was 18 per 1000 while the U.S. overall was 10 per 1000 in 1989: the low-birth-weight rate of Black children is ranked the highest in the U.S. and nearly double the national average; Black children make up 15% of the J.S. population younger than 15 but account for 52% of reported pediatric AIDS cases (children's Defence Fund, 1991).

How do the progeny of caste-like minorities "survive"? What strategies have they developed as a response to barriers in the economic and social structure. Answers to such questions must be sought in the strong role the family can play in human development.

THE BLACK FAMILY

Notwithstanding the fact that the continent of Africa is vast and has a host of different groups of people with various languages and customs, African Americans evolved as a distinct ethnic group and a collective group identity was borne out of

the realization that, as Comer (1972) puts it: Facing extreme racism with too much group division and too little power, Blacks had a long row to hoe." (.p. 187).

Family life around this time was romantically described in the South as having unique characteristics, as being extended and having substantive existence beyond a simple interlocking of dyadic relationships (Holloman and Lewis, 1978), a kin network that resembles that of African extended families and lineages (Jack, 1978).

The migration North and the search for better economic opportunities resulted in Black families leaving behind a supportive, familiar, extended communities that were reinforced as "highly unstable" families that were "approaching complete breakdown" (p. 127)

Thus, was sparked a closer examination of the Black family living in the city and the contrasting finding of the "adaptational strengths and resiliency" of Black families surviving the challenges of urban living (Billingsley, 1968).

Further, Stack's (1974) ethnographic study of urban Blacks reveals a pattern of cooperation and mutual aid among kin, who do not necessarily live together, diffused over several kin-based households, as a strategy of coping with poverty (p. 31). She contends that past descriptions of Black family life have overlooked the interdependence and organization among kinsfolk and have instead focused on female headed households and illegitimacy as aspects of disorganization among families.

Jack (1978) reports that the extended family is "well established in American cities" and calls into question the hypothesis of Talcott Parsons (1959, p. 241) that the extended family is dysfunctional in democratic and industrial societies (p. 241).

More recently, the term "fictive kinship" has been used to describe Black family life (Ogbu, 1982). The term is taken from anthropology to refer to kinshiplike relationships between persons not related by blood or marriage but who have some reciprocal social and economic relationship. However, in the case of Black Americans the term is used in a wider sense to convey the idea of a brotherhood and sisterhood, a sense of peoplehood.

Thus, the research indicates that Black family life is organized, although it may not be around a pattern that is favored by the dominant society. Black children who grow up in a predominantly Black community, like the inner city, are raised with a collective view of success which conflicts with the individual achievement that is stressed in school. Let us now turn to the empirical evidence and how it indicates that the family, whether it is extended or nuclear, can enhance resiliency in children.

EMPIRICAL EVIDENCE

Many familial factors can be outlined in contributing to resiliency in children. This discussion will focus on four: Parental characteristics, parental expectations, fostering a self concept and the family belief system.

PARENTAL CHARACTERISTICS

Werner and Smith (1982) ascribe the ability of some children to do well under difficult circumstances to the characteristics of the caregivers. They found that the mothers and caregivers of the resilient children were more attentive and had positive attributes described as intelligence, warmth, indulgence with self-control, and confidence in their child-rearing style. Block and Block (1980) also characterize the parents of ego-resilient children as competent, loving, and having shared values with their children.

A critical factor in those who were able to withstand environmental risk in Rutter's (1979) study was a warm, secure and empathetic relationship between parent and child. In such homes only 25% developed a conduct disorder compared to 75% in homes in which such supportive parenting was lacking.

The literature thus cited has been done primarily among White impoverished families. Although very little research has been done on how Black parents can facilitate resiliency in their offspring, one would expect them to possess all the characteristics described above and in addition demonstrate a strong sense of identity that they can transmit to their children. Given the minority status of Black children in the wider society, the home takes on a salient role of transmission of cultural values and offering the child appropriate role models.

PARENTAL EXPECTATIONS

High parental expectations has been consistently found as contributing to resiliency among children. (Williams and Kornblum, 1985, Clark, 1983). For example, Mills (1990) found that parental belief in their offspring, and the ability to convey to children that "You have everything you need to be successful-and you can do it" played an important role in reduction of problem behaviors among the disadvantaged community in an impoverished housing project in Miami that he studied.

In contrast, Ogbu (1982) argues that Black children are ambivalent about schooling and are discouraged from exerting academic effort because of the contradictory messages conveyed by their parents. Although parents may verbally stress the importance of education, their actions and discussions about unemployment, underemployment and discrimination cancels out the encouragement. When children look at the wider society they inhabit, they find these ideas confirmed and fail to develop serious attitudes and perseverance in the

academic field. Ogbu (1982) acknowledges that the school system has failed Black people but nevertheless Black parents need to "work with" rather than fight the school system in order to increase the school success of their children.

PROMOTING A POSITIVE SELF CONCEPT

In negotiating the school system, many children may have self concept problems, but for Black children this includes the alienating effects of racism. White children may also lack a support person but the process of obtaining such a supportive relationship is not as difficult as it would be for Blacks who are not numerically well represented in the dominant society (Sedlacek, 1987). Positive self concept which can be defined as possessing strong feeling of self, strength of character, determination and independence (Sedlacek, 1987) is an aspect of personality development that can be promoted by the family.

Spencer (1987) writes that a Black child's preparation by the parents in understanding and taking pride in their own culture can be a major source of resilience and coping, and its absence can leave a child vulnerable for risk.

Parents can teach children how to negotiate such life tasks in a way that does not allow subordination of self and yet does not alienate the child from an environment that is necessary for success.

For example, Greene (1990) points out concrete ways in which the Black mother can address racial issues about the conditions and barriers they face as a minority group and explore symbols of Black culture so that the child is able to integrate her self identity with the reality of the world. This may be accomplished by reading stories and discussing the historical achievement of Black people in American history.

FAMILY BELIEF SYSTEM

A number of studies of resilient children from low socioeconomic backgrounds point to the role of spirituality and religious beliefs. It is a faith in a higher power that can give meaning to life and provide stability, especially in times of severe hardship and difficulty. It is a faith that gives both child and caregiver a sense of coherence and rootedness, a belief that things will work out in the end (Werner, 1990). It is a similar hope and expectation that helped some children not only survive the Holocaust but have the capacity to be compassionate in spite of the atrocities they experienced.

Coles (1964), in a pioneering study in the South during the period of desegregation in American schools when racial strife was at its peak, supports the notion that the family belief system plays an integral role in the child's ability to withstand societal criticism and prejudice. One of the children he interviewed summed it all up: "My mother believed that there is a lot of evil in the world, but

she believed in love, God's love and our own kind, the kind I grew up with, the kind she showed us during all those grey and cloudy days."

CONCLUSION

This paper was an attempt to describe the Black family and explore ideas that the empirical literature has located within the family as contributing to resiliency in children. Future research needs to investigate this interesting area of psychology, and especially how resiliency operates in environments of racism, either institutional or informal. The paucity of studies that capture the unique experience of Black children and resiliency, warrants further investigation in this area.

Another area for future research is to ascertain whether resiliency has a cross-cultural viability and if so, how it develops in cultures outside the U.S. Does resiliency have the same meaning in Boston, Massachusetts, as it does in Soweto, South Africa? Are the adaptive mechanisms used by the poor and marginalized in the U.S. the same for those faced with a similar situation outside the U.S.? Such findings promise to be hopeful for healthy growth and development on a national as well as international level.

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INTERVENTION MODEL FOR
WORKING WITH LATINO FAMILIES

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Given the unique and complex set of circumstances which influence Latino families in the United States (particularly in Northeastern cities), it is urgent that mental health practitioners develop new and innovative approaches to providing effective services to this community. Traditional mental health approaches have fallen short of intervening in culturally appropriate and relevant ways. As clinicians who are seeking to enhance the relevance of our service delivery to this community, it is important to note that traditional models of practice are not working. In an era where we are enduring our own transitions as a profession, let us take this opportunity to look at approaches which will more adequately address the needs of this important community.

The Latino community in this country cannot be understood in the context of the North American/Eurocentric experience. Latinos who have (im)migrated to this country as well as those who have been born here have been formed by a diverse history. We have endured many cultural traumas as products of a colonial legacy. This contributes to what can be termed a cultural "identity crisis". The daily conflict which is experienced through language and cultural barriers in a racist environment, is worsened by the urban experience. The problems of urban life, unemployment, poor housing, health care, education, the scourge of substance abuse, and youth violence create the social environment within which many Latino families live. As mental health practitioners, we have a great opportunity to enhance the lives of our Latino clients and communities.

The following model comes from our experiences in practice with Latino children and families, in community and school based settings, in Boston. Our perspective is as bilingual/bicultural social workers. Our goal is to serve families who live within an oppressive environment in a proactive manner.

Multi-Modal Treatment

It has been our experience that the capacity to intervene with a Latino family on multiple levels positively influences outcome. Multi-modal treatment is defined as the ability to take various members and groups within a family and treat them in various therapeutic contexts. These contexts include individual, group, and family therapy. Group therapy can include couple and sibling treatment, as well as extra-familial groups such as age-specific children and adolescent groups, parent groups and multi-family groups.

At the Children and Families Clinic of The New England Home for Little Wanderers, we provide clinical services to the bilingual learning and adaptive behaviors (LAB) classroom at the Agassiz School in Jamaica Plain, Massachusetts. At one point in time, we had all the children in this classroom in individual and group treatment once per week. We offered unstructured family therapy on an as needed basis, generally once a month, and more frequently during crisis. As well, most of the mothers participated in a weekly mothers group meeting. Family treatment was generally provided on an outreach basis, and transportation was provided for the mothers group. The children's treatment was provided, generally, on the school site.

These multiple contexts allow for a greater depth and breadth of intervention and offer a better clinical prognosis for the family as a whole. Another fruitful area for intervention is that of multi-family group therapy. Especially for a Latino population, this sort of context allows for broad issues such as isolation, cultural conflicts, and racism to be addressed.

Outreach Treatment

The inner city poor family can well be expected to be mistrusting of persons and agencies deemed as "there to help". It is our experience that the most important phase of treatment with the Latino families we have worked with, is the initial "joining" stage. In this initial stage, the clinician can establish him/herself as prepared to enter a client-centered orientation. This often entails an openness to meeting the client in a context other than the clinicians office. Often multiple missed initial appointments are met with frustration by the clinician, the client is deemed resistant and the case is subsequently closed. In the case that the clinician makes a phone contact, this frustration often comes through unexamined, thus exacerbating the client's feelings of mistrust, powerlessness (specifically if it is, say, a parent responsible for the attendance of an adolescent), and hence alienation. On the other hand, the clinician can ask the client if it might be easier for the initial meeting to occur in a more neutral or safe context, such as the client's home. Often with pre adolescent and adolescent boys who are manifesting behavioral symptoms, the family may passively be resistant to treatment. There is a strong relationship between the family patterns which lead to acting out behavior and the family's inability to follow through with treatment (even though they may initially seek treatment). These dynamics are particularly frustrating to the clinician working out of traditional models which expect the family to take major responsibility for getting themselves to treatment. On the contrary, the clinician must be open to understanding the family on their "resistance". This openness sets up a dynamic of validation of the client, and the clinician is often seen "with new eyes" by the family. This initial meeting need not necessarily occur in the client's home. What is more important is the offering of a possibility of an alternate context for this initial contact to occur. If the clinician, say, does not feel safe in the client's neighborhood (chances are neither does the client), we recommend that the clinician state this fact and continue the search for a middle ground. Schools, clients

workplaces, churches, or various other locales are possible options. After this initial encounter, a contract can be entered into that may, or may not, involve session attendance at the clinicians office. Regardless, a validation dynamic has been established which will color the rest of treatment, and can be drawn upon as treatment proceeds.

Out of Isolation: Bridge Building Between the Family, School and Community

Many of the Latino families we encounter are unable to break out of the isolated environments of the inner city. Clearly, this isolation is social and economic. Many family members are uncomfortable venturing out of their own communities due to a broad range of social circumstances. Urban violence, substance abuse, language and cultural barriers, and geographic isolation are a few of the factors which influence the family system. Additionally, many Latino families rarely seek help outside of the extended family network. In this sense, a goal of the therapist is to become part of the family's support system. Within this context, the influence of extended family as a natural support system often goes untapped. The extended family, "vecinos" (neighbors), and community based organizations can help address significant concrete and treatment needs of the client system.

Given the significant role of extended family as well as other community members for support, these networks can be tapped throughout treatment. Child care, transportation, and emotional support during a crisis are often supports which our institutional settings cannot provide adequately. Initially, when joining with the client system, one may ask the family to identify key members of their extended family/natural support system. Often, as isolated as the family may be, there is a small network in place. Identifying these persons and developing a collateral relationship with them, should be a goal of interventions. This also seeks to establish the clinician as a member of the family's "helping network". Many Latino families rarely seek help outside of the extended family network. In this sense, the more that the therapist can appear to be part of the family's support system, the more effective they can be in helping the family access their own resources.

Additionally, helping the family identify formal community supports, such as community centers, health clinics, social clubs, etc. can be an initial goal. These may also serve as alternative community based sites to meet with the client (when appropriate), if the clinician and/or the client are unable to meet at the agency or in the home.

Initially, it is helpful to establish relationships with key family members, especially those who may be reluctant to participate and hinder other family members from participating. Even token participation by these family members will serve to support the treatment. A phone call, asking the family member for their opinion on a family decision, can be a significant intervention when and if the family member in question is not threatened by the other family members'

involvement in treatment. An example of this which we often experience related to the fathers/husbands in these families. When they are present in the life of the family, their role is always significant. Often within the patriarchal context of many Latino families, the mother's role is seen as the parent who deals with issues relating to the children (i.e. school, medical appointments, etc.) and the father's role is seen as that of the provider. We believe it is important in these situations for the clinician to solicit the father's support for the treatment. This can be done simply by asking the father what he sees as important goals for his children/family to accomplish during treatment. If the father responds positively, the clinician has been successful in receiving the father's "blessing", thus allowing the other family members to engage with the therapist and not dishonor their loyalty to their father. As treatment proceeds, the clinician can engage the father on a basis which is not threatening. The father may recede from treatment afterward. In this case, the initial contact is significant because the clinician can later reaccess the father more easily than if there had never been an initial contact.

Transcending Traditional Mental Health Practice: Going Beyond the "Clinical Hour"

In line with our earlier statements about the importance of the initial joining phase of treatment, is that of remaining open to the client's definition of what would be helpful. It can happen that in the initial phase of treatment there may occur a clash of agendas between the clinician and client. The client may see the clinician as most helpful as a resource to assist with the accessing of concrete resources. The clinician may have a more problem oriented focus, and see the client's request as "manipulative", "defensive" or perhaps inappropriate for the clinical therapeutic context. We see this client request as an opening in which the clinician can be seen as not "merely" talking, but doing, as well. Providing for concrete services, while important in and of themselves, further establish the clinician as a potentially trustworthy person and potentially helpful in other contexts. Other than facilitating the acquisition of concrete resources, the clinician can assist with transportation, serve as an interpreter (both linguistically, if bilingual, but also culturally and strategically), and with the making of phone calls. Thus a basis is established, which can be built upon, to then address other areas in need of resolution.

Boundaries and Limits

Given the non traditional model we espouse, an important piece of the puzzle is that of balancing boundaries and limits. As the clinician extends him/herself to be more accessible to the client, specific transferential issues often arise. These include seeing the clinician as a savior, a friend or a threat.

The Latino families which we work with have rarely experienced a clinical intervention which goes beyond the walls of an agency. More and more families which we have come in contact with have experienced success within the scope of a

family preservation model. This is an invaluable asset as it gives the client experience with intense intervention and, eventually, closure.

A common example is the client who has been helped, is now open to intervention, and wants to give something back. This often plays itself out through invitation to a meal. Here the clinician needs to decide if having a meal with the family is a helpful intervention or one that sets up unrealistic expectations. Then, if the clinician chooses to decline (which we most often do) how it is done, is important for the relationship. We will often state, in a culturally respectful manner "Oh yes, that sounds nice!'. Often this is a sufficient response. In the case that the issue is raised again, a more appropriate response may be reminding the client of your role as a professional by stating that your schedule does not allow for a meal. What appears to be most important to the client in this case is not the meal, but the invitation. We believe it would have been less helpful to have said "Oh, no I don't do that" or some other expression of discomfort or inappropriateness of the invitation, thereby inhibiting the client from expressing themselves to the clinician.

In the separate case that the invitation to the meal is in the present moment, the clinician has a separate task. Again, he/she needs to decide, if this is a clinically sound option meeting a therapeutic need (say, joining with the family). We have found that the expressing of gratitude at the invitation, yet the impossibility of acceptance at the moment due to other circumstances, again respect the invitation but declines the reality, when this is in the best interest of treatment. The expression of gratitude at the invitation always acknowledges the good intentions of the client, no matter what the clinician's response may be.

Another very helpful way of establishing boundaries and limits, in an outreach context, is reminding the client that this is your job. As the clinician senses that the client relationship is coming close to an invitation to greater intimacy (a meal, a card game, etc.), he/she can again offer his/her gratitude and state that they have commitments to other clients. This gives the message that the present client, while cared for and attended to by the clinician is in a general type of relationship where the client's needs are met directly, but the clinician's are not. We believe that these seemingly small maneuvers are of great importance within treatment.

Clinical Issues Specific to Latinos

The bulk of our caseload involves single mother families, with acting out sons ages 6-19. We have found a particular reluctance on the part of many mothers to manage the behavior of their sons. While many mothers will resort to rageful outbursts, it seems the exception, the mother who will consistently address the undesired behavior of her son. We have come to understand this as the "macho dynamism" as played out in a single mother and acting out son dyad. The mother, we believe, seems to feel that the son is in possession of special rights as a male. These rights permit aggressivity, temper outbursts, and the depreciation of females. Often the mother feels that to discipline these behaviors of the son, is to emasculate

him. Additionally, within Latino culture, the mother sees limit setting in conflict with her role as nurturer. This "feminine dynamism" as communicated to the son often leaves him feeling powerless, never having had a consistent limit setting presence throughout his life. These dynamics are in direct opposition to the expectations of the dominant culture where females are the primary limit setters in the school setting.

Much of our work in these situations revolves around encouraging mothers to discipline their sons, that disciplining them is in fact not taking away from their maleness, but teaching them to be responsible males. Much of the work with the sons includes addressing the unconscious association with absent fathers and the displaced anger toward the available parent. This work is facilitated by individual, group and family interventions. In the case where the clinician also works with the child in an individual and/or group context, he/she can model for the parent, appropriate ways to set limits and manage behaviors by offering examples of how this is done within the clinician's contact with the child. Additionally, when the work is home based and the child is present, the clinician can "coach" the mother on how to respond to her child. This can be facilitated through role playing and therapeutic games.

Termination and Follow-up

Much of the work we have described involves a commitment on the part of the therapist which, in turn, fosters a dependence on the part of the client. At termination, these issues must be addressed. We believe that to open a family up in the way we have described imposes a responsibility onto the clinician at termination. Some degree of connection and follow-up is required so that the growth and change that has occurred does not disintegrate. We advocate, instead of a concept like that of termination (with its death-like implication), one of continued connection, though not necessarily regular in nature.

We allow and encourage families to keep in touch. We will continue to be a resource after the formal relationship has ended. This may involve connecting the family to another service, or six months later assisting once again, with translating a document or attending a meeting together. We also encourage an "institutional transference" where the client can feel that the particular agency can serve as a resource in the future. In this case, a particular person if other than the clinician, needs to be identified and introduced as the contact person. In the case that the clinician leaves the agency, a forwarding contact number can be left so that calls can be forwarded if appropriate.

All of these options involve more work unquestionably, but the integrity of the initial "we are here to help" depends upon it.

Case Example: The Ramirez Family

Gustavo, age 11, his sister, Joana, age 12, and mother lived in a battered women's shelter because Mr. Ramirez, the father of both children and Mrs. Ramirez' husband, had been repeatedly physically abusive to her. He was an alcoholic, the children both witnessed the violence and occasionally were also recipients of violence from their father.

Mrs. Ramirez was encouraged by the shelter staff to seek counseling for Gustavo. He had recently gained a significant amount of weight, and fights between him and his sister were consistently escalating in frequency and assaultiveness. Mrs. Ramirez waited until she was in permanent housing to seek counseling for Gustavo.

Mrs. Ramirez called the Family and Children's Clinic of the New England Home for Little Wanderers, within a week her son was assigned an individual counselor.

During the initial phone contact Mrs. Ramirez indicated that she was enthusiastic to have her son in treatment and that transportation would not be a problem, as she had an automobile.

The counselor met with Mrs. Ramirez initially by herself and collected a history. In the next meeting, Mrs. Ramirez brought Gustavo and he met individually with his counselor. Gustavo used his first session to actively process the violence he witnessed and how he had coped with it. His emotional state was very stoic and matter-of-fact. After three or four sessions, a family meeting was convened to address Gustavo's progress and to raise issues from his individual treatment in the family context. Gustavo addressed his anger with his sister as well as his feeling of loss and disappointment with his mother. She, on the other hand, acknowledged that she treated him differently from his sister, and was not sure why. We decided that family meetings would be a good idea.

Gustavo was referred to a group for 11 year old Latino boys with acting out/aggressive impulses. The group was run by his individual therapist. The focus for Gustavo in the group was to work on his social and peer skills, anger/conflict mediation, sharing and jealousy mediation ("sibling rivalry"), among other issues.

Family meetings which originally focused on Gustavo's "constant fighting" with Joana, eventually progressed to the role of Mr. Ramirez, who was now beginning to become reinvolved with the family. Each member discussed their ambivalence about trusting their father again.

A meeting was offered for Mr. and Mrs. Ramirez to address some of these issues. Mrs. Ramirez chose not to follow up on this offer. Eventually Mrs. Ramirez requested service for Joana and entered a mother support group herself. Family

treatment continued to address the father's abuse and its aftermath in the family. Eventually Mrs. Ramirez lessened her husband's rule in the family due to his "treating the children in ways I didn't like".

The family has been in treatment for five months now and has made significant progress. The interventions have been carried out by 4 clinicians. One who ran Gustavo's group and saw him individually. Another who met with Joana, and two others who ran the mother's support group. If possible, Mr. Ramirez would have been included in some capacity in couple/family meetings (when he was "part" of the family) and referred to group treatment, had that seemed appropriate.

A note about managed care: A case like this would look much different given an 8 or 12 session model. This case was managed through three medicaid sources (Gustavo, Joana and Ms. Ramirez) and was regularly under the threat of termination as during the application process. Further creativity will be called upon to address the daunting challenges and/or an acceptance of smaller incremental change as the expected outcome ("return to functioning").

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Cultural Awareness Training for the Helping
Professions: A Holistic Model and
Principles for Crosscultural Communication

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Introduction

One of the greatest challenges facing the human services arena, or for that matter any societal institution, is to be responsive and sensitive to the issue of cultural diversity as it delivers its various programs. To be responsive and sensitive requires that there be a degree of awareness about what I call the "cultural-in-self" and the "culture-in-the-other" as institutions implement their programs.

The purpose of this discussion is broad. First, I will briefly explore how the need for cultural awareness became a salient societal issue. In doing so, I will examine various models that were developed to respond to this need. Next, I will consider barriers to experiencing cultural awareness and effective crosscultural communication in the helping relationship. I will then discuss a holistic model for cultural awareness training, emphasizing a holistic definition of culture and principles for crosscultural communication. The intent of this holistic model is to provide the context for learning more about the culture-in-self and the culture-in-the-other. Finally, I will also discuss the implications of this model and the accompanying principles of crosscultural communication for human service organizations, educators, managers, and policymakers with respect to providing crosscultural training and with respect to a vision for the future.

What does it mean to have "cultural awareness" and what does it mean to provide cultural awareness training and perhaps to even institutionalize that training? To answer these questions, a number of ideas or concepts need to be identified and explored. These include: the concept of cultural awareness, a definition of culture, the principles of crosscultural communication, the notions of the culture-in-self and the culture-in-others, the definition of and process of institutionalization, the issue of what can be called a "subject/object dualism" in relation to culture, and the idea of a "holistic model." These ideas or concepts will be identified and integrated into the body of this discussion with the intent of creating a context for curiosity about how to conduct cultural awareness training. Hopefully readers will want to know more about these ideas or concepts and will want to more fully explore and understand them. The further hope is that readers will be challenged to translate and use some of these ideas in the roles that they play in various institutional and life settings.

Cultural Awareness Becomes a Salient Societal Issue: Early Models Designed to Respond to the Need

Historically, concerns about cultural awareness and crosscultural communication developed in the international arena as a response to the training needs of a number of international organizations. The purpose of many of these international organizations was to provide technical assistance and services in other countries. Some of these organizations were expanding corporations trying to do business in other countries; others were helping organizations trying to assist developing countries. As these endeavors began, however, it was recognized that people needed to have some understanding about the new environment in which they were to work. They needed to know what worked and what did not work in the cultures in which they would be working. Training needs, therefore, were related to the task of how international organizations could both provide successful public, community, and human services in these settings and deliver other services as well. It was in response to these needs, then, that various methodologies were developed within these organizations to address these issues.

According to David Hoopes (1979), the first programs that emerged in response to these needs were developed for Americans. The approach that these early programs employed was called the "university model." The primary focus of these programs was to provide information about the cultural context of the country where the service provider was to work. The language, customs, history, religion, geography, economics, and arts of each culture were included in this approach. It was primarily a cognitive endeavor, comprised of lectures, seminars, packets of information, and audio-visual material. In short, it was an information-sharing approach, designed to increase the person's knowledge about the other culture.

The reaction of participants to this model, however, was unfavorable. Across the board, feedback indicated that the approach had provided the participants with useful cultural information but had failed to enhance their ability to function in another cultural context. Additionally, the information was seen as only partially useful since it did not include the infinite variations of cultural practices and behaviors that participants would encounter. Using this model, participants felt that their ability to perform their designated professional roles remained greatly diminished because they were unable to apply their skills in a culturally appropriate manner.

The second model to be employed for cultural awareness and cross-cultural communication was the "human relations/sensitivity training model" (Hoopes, 1979). This model was an attempt to apply the domestically derived learnings of the human relations field to the international experiences of people. It relied heavily on an approach that employed methods for experiential learning.

The human relations/sensitivity training model proved quite useful in helping people encounter differences. That is, it was successful in creating the opportunity for people to openly look at their differences. However, aspects of this model were found to be dysfunctional in cultures that valued behavioral norms antithetical to the norms of openness, self-disclosure, direct confrontation, and so on. One such example is the Japanese culture. Many professionals in this area today consider this model to be culture-bound and of limited use in crosscultural situations.

In the early 1970s, an approach was developed that combined crosscultural information-sharing with the experiential learning methodology. This new approach was labeled the "integrated cognitive/ experiential model" (Hoopes, 1979). It is the cornerstone of the cultural awareness and crosscultural communication field as it presently exists. It should be noted, however, that this field is still emerging and is not yet completely systematized. A number of additional methodologies have been developed, in fact, that combine information-sharing and experiential learning. Many of these methodologies have been developed, in fact, that combine information-sharing and experiential learning. Many of these methodologies are also designed to demonstrate, conceptualize, document, and allow for the expression of cultural differences.

As approaches to cultural awareness and crosscultural communication were being redefined on the international level, a need for similar approaches was beginning to surface in the United States. Public, community, and human service arenas were being confronted with demands made by political activists during the 1960s for greater relevance and responsiveness to a multiethnic, pluralistic client population. The African-American community and the Hispanic community, gradually followed by others, were the first communities to raise the question of relevance in delivering public, community, and human services. Activists in these two communities pointed out that the philosophical basis for the existing system for delivering services was the melting pot theory and that this theory simply failed to take into account the many valid cultural perspectives present in the United States.

In response to this outcry, public, community, and human services agencies and educational institutions began to hire individuals from minority communities and sought training programs in order to reeducate their existing staffs. Again, the human relations field became a prime resource for providing sensitivity and awareness skills.

Numerous training programs emerged. For the most part, the focus of these programs was to provide information about minority cultures, as well as to work on communication, racial confrontation, and awareness skills. If nothing else, a context was created for beginning to better understand barriers to cultural awareness and effective crosscultural communication in relation to the helper-client relationship.

Cultural Barriers in Helping and Providing Services

Paul Pedersen (1975) points out that without cultural awareness training the "culturally incapsulated" human service worker becomes counterproductive. He suggests that the untrained worker is probably unaware of the cultural dynamics that he or she brings to the helper-client relationship. Such a worker views the relationship from a biased perspective, favoring the mainstream culture and the dominant socio-economic class by using concepts of health, normalcy, and happiness that have been developed in that context. Because of this bias, cultural differences are often interpreted as deviant behavior and culturally indigenous coping mechanisms can be ignored or overlooked.

One result of being culturally incapsulated is that the worker, as well as the client, misses the opportunity to learn new ways to resolve problems, thus impeding the helping relationship. Another result is that clients become alienated because they may feel that the worker is unable to understand, to legitimize, and to relate to their realities. Finally, since they can only be effective with a small number of clients whose behavior is similar to their own, workers who regularly find themselves in this type of helper-client relationship tend to become discouraged.

Aside from cultural bias, what other cultural barriers are there that interfere in helping and providing services? How can these barriers be addressed? One field of activity that provides some clues stem from the mental health arena, insights derived from them seem transferable to all public, community, and human services since the "helping relationship" is the basis for the delivery of any kind of human service or helping profession.

Within the field of intercultural counseling, there is general agreement that cultural barriers interfere with communication. Clarke (1975), Vontross (1975), and others have described some of these barriers. For example, in describing intercultural counseling in the United States, Vontross (1975) discusses "radical attitudes, ignorance of the client's background, language barriers, the client's unfamiliarity with counseling, Black self-disclosure reserve, and sex and race taboos" as counterproductive elements that impede the helper-client relationship.

There is also a degree of consensus among intercultural counselors that, in order to alleviate problems such as those noted above, cultural awareness training is needed. However, a particular kind of cultural awareness training is needed. This particular kind of training, most counselors agree, would be successful if it brought about the following:

- an understanding of interaction processes as opposed to information about other cultures;

- an understanding of and empathy for the values, assumptions, and attitudes of the other culture;

- insight into one's own cultural context, values, assumptions, and attitudes;

- an understanding of the social roles operating in a society; and

- the building of skills that will help enhance and promote success in these roles.

While personal sensitivity, openness, and adequate professional training are absolutely necessary, effectiveness in the intercultural helping relationship is believed to be dependent on the worker's ability to "communicate crossculturally" (Clarke, 1975). Communicating crossculturally requires that a worker have a degree of awareness regarding the five issues identified above. To have cultural awareness means, therefore, that one has a sense of the culture-in-self and the culture-in-the-other as each is expressed through values, assumptions, attitudes, and social roles, and as each is experienced in interactions between people. It means not making an *object* out of the person who is culturally different from you, but rather learning to appreciate the valid, subjective cultural reality of the other person as you learn to appreciate your own valid, subjective cultural reality. It means understanding that the culture-in-self limits how one perceives reality, and thus can cause one either to act defensively when encountering differences or serve as a stimulus for growth. The reverse is also true regarding the culture-in-the-other. It means having an awareness that when these cultural barriers emerge as people from different cultures interact, one must first *look inside* to uncover one's own limitations. With this kind of awareness, crosscultural communication is enhanced and cultural barriers in helping and providing services may be transcended.

What interculture counselors have suggested, then, is that there is a *subject-object dynamic* at play that can impede the helper-client relationship. Rollo May (1979) contends, for instance, that there is a subject-object duality inherent in Western culture that impacts on the helper-client relationship. He maintains that not only is the individual client objectified as an object with this dualistic perspective, but the entire cultural context of that individual gets viewed as an object. Berger (1975) suggests that a similar dualism lies at the core of Western cultures and that this perspective allows for separation and distance between the self and the world. Henry (1963) alludes to this condition and Danielian and Klubach (1969) call this condition *mechanistic dualism*. The argument is that the experience of "separateness" - whether it be the separation of one person from another, or the self from nature, or even of one's objective self from one's subjective reality - can be attributed to mechanistic dualism.

The implication of each of these conceptualizations is that cultural awareness training that is based solely on Western thought must be scrutinized carefully because of the dualistic tendency inherent within it to make objects out of other individuals and their cultures. What is required is a redefinition of the cultural

dynamics between the helper and client so that there can be the experience of a *subject-subject relationship*. Another way of saying this is that the people involved in a helper-client relationship must both be aware of and experience the culture-in-self and the culture-in-the-other. They must understand that cultural reality is created interactively from the inside out, and not the other way around, and that this reality is a valid, ongoing process. They must also understand that people and their experience of cultural reality are not objects.

A large number of methodologies that are designed to enhance the crosscultural communication process have been developed in the human service field or helping profession. In a number of public, community, and human services situations or helping situations, structured experiences and open-ended discussions that focus on specific aspects of the crosscultural communication process are being applied with varying degrees of success. Some of these methodologies address the crosscultural communication process as a whole, while others concentrate on an in-depth, exhaustive analysis of some aspects of the crosscultural communication process.

Stewart (1971, for example, employs what he calls the "contrast American" methodology. In this approach, the author has concentrated on identifying key elements of American culture and has designed experiences that facilitate gaining awareness of the American cultural context by contrasting it to others. This approach directly addresses the issue of dualism by demonstrating its existence in the American cultural context. Other methodologies approach this dualism indirectly by demonstrating communication barriers in the helper-client relationship

Whatever the approach, the point of these methodologies is to create an awareness about operating with a dualistic perspective and to show that operating from such a perspective is a culturally based phenomenon. Unfortunately, there continues to be a tendency in these approaches to objectify people and their cultures even while pointing out the dualism. Over the last two decades, however, there has been some movement away from using a dualistic approach to understand dualism toward a search for a more holistic approach. The need is to have a way to be able to look at the "whole person" within his or her cultural context, without that person and his or her culture being viewed as objects.

A Holistic Model for Developing Cultural Awareness: An Innovative Approach

A holistic model recognizes that each of us create our own reality wholly according to the nature of our beliefs (Seth-Roberts, 1972) and that many of these beliefs are culturally based. While some beliefs are acquired as a result of reacting to personal circumstances or of accepting the ideas of significant others, cultures provide us with a set of assumptions and values (cultural beliefs) about ourselves and the world around us. These cultural beliefs are carried in the mind by each of us and serve as the context within which we relate to ourselves, to others, and to our

physical and spiritual environment. Most people are unaware of cultural beliefs and assume that their cultural assumptions about the nature of humanity and the world, which are uniquely internalized by them, are right and natural. Also, most people unknowingly and blindly accept, modify, or reject cultural beliefs in accord with their changing life circumstances. Beliefs about the self and the world, therefore, structure one's reality and cultural beliefs about the self (i.e., ideas about one's mind, body, and spirit) and the world (i.e., ideas about the physical and spiritual worlds) both create the person and are created by the person. Each individual, it follows, experiences his or her culture in a unique way. Thus, the whole person must be viewed in terms of his or her unique experience of beliefs about his or her environment - i.e., his or her physical, social, and spiritual life. The holistic model places the whole person at the center of his or her universe and places emphasis on understanding the process by which one creates one's own reality in line with one's own beliefs. That is, the whole person is placed at the center of an interactive and co-creative process with his or her environment (internal and external).

The following discussion outlines a framework for a holistic approach to developing cultural awareness. This approach is grounded in a holistic definition of culture and in principles of crosscultural communication. It can serve as the basis for the development of cultural awareness training programs for the helping professions as defined in this paper. This approach in turn can become the cornerstone of a vision for institutionalizing cultural awareness within the human services arena and the helping professions and at various societal institutions.

The holistic definition of culture used in this approach to achieving cultural awareness was developed by Interculture, Inc., a consulting and training organization that I and a small group of close, crosscultural friends cofounded. The definition was developed to demonstrate that culture is an ongoing process in which all individuals of a particular group are involved. As these individuals interact with one another and with other groups, they develop patterns of behavior that are most suitable for their life situations. Culture cannot be described in static terms of "there" and "then" as if it was an object completely developed; nor can elements of dress, language, foods, customs, values and beliefs be described without taking into account the individual's unique experience of these elements. Having knowledge, therefore, about a culture is meaningless in trying to describe a person without understanding that person's interpretation and experience of that culture. Forming judgments about an individual's behavior by comparing it to that of another individual or to general knowledge about a culture is equally meaningless. It is people's unique interpretation and experience of their culture that constitutes what I call the *culture-in-people*. Developing awareness about the culture-in-people (i.e., in-the-self and in-the-other) constitutes what I refer to here as cultural awareness. The holistic definition of culture reflects this perspective.

- a problem-solving process in response to the human environment-physical, social, and spiritual;

- a process resulting in an established pattern of dealing with human life situations;

- a process developed by and therefore functional for the particular group of people who developed it in their context of time and space; and

- an ongoing process transmitted to new members also in a context of time and space.

This definition implies that an individual who is born into a group constantly interacts with his or her culture by accepting, modifying, or rejecting existing cultural patterns. Individuals and their culture are thus involved in a constant dialogue through which they define each other.

Every culture has a system by which individuals are classified. Examples of such classification include socioeconomic class, ethnicity, leadership, and so on. These classifications, however, neither completely define, nor wholly characterize the total cultural context. When learning about a culture, it is important to be aware of and to understand the classification systems of that culture. Yet such knowledge cannot be used to evaluate or interpret the behavior of individuals without taking into account their experiential perspective. A holistic approach for developing cultural awareness encourages an understanding of the individual's unique experience of his or her culture. How has an individual uniquely integrated the patterns of his or her culture? What has the person accepted, rejected, or modified in his or her unique way to fit his or her own life circumstances? In what ways is the person involved in the ongoing process of his or her culture?

The following principles of crosscultural communication are supportive of the above holistic definition of culture. They can be used to guide individuals through a crosscultural communication process. Again, these principles were developed by Interculture, Inc., and can serve as the basis for developing cultural awareness training programs for the helping professions. The principles establish a "subject-subject" relationship between individuals and cultural groups by legitimizing all of the interacting cultural contexts. They further allow each individual to choose his or her style of value confrontation by not requiring verbalization, but rather by encouraging involvement in the process of value confrontation.

The principles of crosscultural communication represent *a set of realizations* that are important to keep in mind as one engages in the process of increasing one's cultural awareness. The principles are as follows:

- All cultures have their own logic and coherence; each culture possesses its own validity and value.

- All persons are products of a culture or cultures, but each person integrates his or her culture in a unique way.

- Differences are potential sources of learning and growth rather than reasons for defense or attack.

- Learning about culture-in-people is more than a cognitive exercise; it is an attitudinal and affective process.

- The process of confrontation between different value systems is potentially a positive learning and growth experience.

- Crosscultural communication can occur best when: an individual is aware of his or her personal assumptions, values, and beliefs, as well as the way these are culturally based and the manner in which they limit him or her; and an individual is aware of another person's assumptions values, and beliefs, as well as the way these are culturally based and the manner in which they limit that other person.

Implications of the Holistic Model and Crosscultural Principles for the Helping Professions in Providing Cultural Awareness Training and a Vision for the Future

It can be argued that any institution or organization that is engaged in providing helping services (human services, educational services or otherwise) to a diverse population must find ways to enhance the level of cultural awareness within that institution. That is, it must find ways to institutionalize a process to enhance cultural awareness. The institution must also examine itself in terms of policies and practices that limit effective crosscultural interchanges. To do this, cultural awareness training or, eventually an institutionalized process that uses the holistic approach and crosscultural communication principles is recommended. The effort must be geared toward understanding the cultural basis of interactive processes, values, assumptions, attitudes, and social roles in one's self and in others, as well as towards understanding how these elements impact on the delivery of services. This approach to cultural awareness training and to institutionalizing cultural awareness at a societal level is a vision for the future. If this is not done, it is likely that the provision of services by the societal institution, in the long run, will not be very effective.

Institutions often need a cadre of people to nurture the spirit of cultural awareness until policy catches up with experience. When policy does catch up with experience, from an institutional perspective, policies with a cultural awareness focus work best when they are directed toward entry into the institution or toward interfaces with the institution. In the meantime, it is important for this cadre of people to continue to clarify and refine their institutional vision. These individuals

can serve as in-house consultants who are both students of their own behaviors and beliefs and who encourage others to be students of their own behaviors and beliefs.

Another important implication of the holistic model is that affirmative action efforts must continue to be vigorously and vigilantly pursued by all institutions in society (particularly those engaged in the helping professions), despite the current climate to dismantle or undercut such efforts. In order for cultural awareness to become part of the fabric (the norms and traditions) of an institution and in order for cultural awareness training to work effectively, that institution must first have diversity represented by its personnel. If current population trends continue, the United States population will be an even more diverse population, comprised increasingly of people of color, as the twenty-first century unfolds. Educators, managers, and policymakers, therefore, cannot hide their heads in the sand and pretend that cultural diversity will not be an issue for society's institutions. To ensure that institutions and organizations adequately reflect the nature of the diverse population, the method of affirmative action continues to be an important vehicle for creating *intentional communities of diversity* in the public (particularly the human services arena and helping professions) and private vectors of work. The danger in not doing this is that there will be an increasing cultural gap between the needs of the population and the personnel of institutions that are trying to respond to these needs.

To illustrate how cultural awareness training can be effectively done for the helping professions utilizing the holistic model and the crosscultural principles, let me use two examples. The first example is one of the several approaches that is used by Interculture, Inc. to conduct cultural awareness training and the second example is that of an educational institution - the College of Public and Community Service (CPCS) - that has been established to educate and train adult learners in a variety of arenas that have to do with helping others. It is hoped that the second example will illustrate how cultural awareness can be institutionalized and thus can serve as a model for other societal institutions with respect to a vision for the future.

One of the approaches that Interculture, Inc. has used to conduct cultural awareness training is to employ a *process-driven strategy* that expands on the integrated cognitive/experiential model. The added dimension is that the training also attempts to get at attitudinal and effective dynamics while exploring the process of creating, internalizing, and experiencing *temporary cultures* in both a culturally isolated context and a crosscultural context. There is both a short and a long version of the training process. The short version employs an experiential introductory component, a case study analysis with guided questions, a role play simulation, and a processing and application session. The longer version employs all of the above and intensive work with temporary cultures. The training, therefore, may be a one or two day experience or can be an even more intensive experience.

During the experiential introductory component of the training, participants are introduced to the holistic definition of culture and the crosscultural

communication principles. This session is generally conducted by a crosscultural team of trainers who model some of the ideas that are being discussed. Participants are encouraged to share their own ideas about what culture is and how they define themselves culturally. No indepth work is done at this point. This component may have some attitudinal and affective aspects to it, but it is primarily cognitive as participants ask questions and engage in dialogue with the training team.

The second component of the training often revolves around a case study that has been developed by various members from an indigenous cultural group. The case history is designed to tap cultural dynamics and the helper-client relationship. Participants have an opportunity to read the case, to ask clarifying questions, and are given *alone time* (often an hour) to answer a series of guided questions. They do not have to share their insights with others unless they choose to do so. The questions are intended to assist the participant in looking inside both for their own reactions as well as for ideas that they can generate about possible resolutions to the issues posed by the case. Here participants begin the process of exploring the culture-in-self and how it might limit them.

The third component of the training revolves around a role play simulation that stems from the case study. Participants are randomly divided into groups and are given the task of more fully developing the perspective of the principal characters in the case study. For example, if the case has a mother, a father, a son, and a helper, there would be four groups and each group would concentrate on more fully developing the perspective of one of the four principal characters. When this is done, one person is chosen to play the role of this principal character during a role play simulation where the helper is attempting to intervene in the case. Respective group members participate during the simulation by offering suggestions to their representative when needed. This is done when the actors may reach an impasse and the representatives are asked to return to their groups for advice. After receiving the advice, the representatives then resume the simulation. This component is designed to get at attitudinal and affective issues related to cultural awareness. Participants also get an opportunity to explore the process of culture and how the individual's perspective on his or her culture evolves.

The fourth component follows the simulation. It is designed as a process component whereby the crosscultural team and participants discuss cultural misunderstandings, intervention strategies, and related issues important to the helper-client relationship in the context of the holistic definition of culture and principles of crosscultural communication. The idea here is to highlight the subject-object dynamic and to provide a safe way for participants to explore subject-subject resolutions.

A more intensive experience is provided by a fifth component of cultural awareness training, although it can be considered an independent component that can be carried out alone. This component involves participants in an opportunity to create temporary cultures and to experience the process of the creation of the

culture-in-self, as well as to interact with the culture-in-others. Here after an introductory experience, participants are arbitrarily divided into at least three groups. Each group has a crosscultural trainer, who will facilitate the work of the group in developing a temporary culture. Participants are asked to suspend as much as they can cultural prescriptions that they bring to the setting and to consider inventing new cultural prescriptions. Each group ultimately comes to some consensus about its societal structure, its norms, it beliefs, its values, and its behaviors for interacting. For example, during one training session, a group decided that the way they would say hello to others is to pull on each other's right ear. After developing these temporary cultures, the three groups are brought together for some prolonged interactions around some universal issue for which all cultures have developed some solutions - like, how should children be educated. Videotaping these interactions can also be useful for later processing. After the prolonged interactions whereby participants function with alternative cultural prescriptions, the crosscultural team assists participants in processing their individual experiences. Again the holistic definition of culture and the principles of crosscultural communication are used as guides for this processing.

The College of Public and Community Service offers another example for cultural awareness training for the helping professions. Given its urgent mission, CPCS has intentionally created a culturally diverse community of students, faculty, and staff. As such, it has become a rich arena for experimenting with this holistic approach for developing cultural awareness and for experimenting with the institutionalization of that approach. A vision for the future is that more institutions can do likewise.

Based on years of consulting experience and on the study of organizational development literature, it can be argued that the process of institutionalization includes the following steps:

1) Identifying an institutional need, problem, or issue. This can be done by an individual or group within the institutional setting.

2) Re-examining what does and does not exist institutionally to address the need, problem, or issue. This can be a formal or informal process, as well as an individual or collective process within the institution.

3) Creating an institutional vision. This can emerge as an idea or an image from an individual or group within the institution regarding a new possibility for operating institutionally.

4) Nurturing the institutional vision. Here an individual or a cadre of individuals or groups within the institution act in concert with the new idea or image.

5) Formalizing the institutional vision with policy. The policy sets the tone and establishes guidelines for a way of operating.

6) Normalizing the institutional vision with institutional practices and/or processes.

To have a phenomenon institutionalized means that it becomes part of the fabric of the way things are done. To institutionalize cultural awareness, then, means that this kind of awareness is valued as part of the way things are done by an institution. The value is reflected in the formal and informal norms that define what is acceptable and not acceptable. More specifically, it means building a process into the institutional fabric of the organization that would create a context for the prevention of people and their cultures being treated as objects. The formal and informal organizational norms would indicate that this kind of attitude and behavior is not acceptable.

Any institutional process for cultural awareness must include: 1) the opportunity to explore the culture-in-self within the institutional context and, more specifically, in terms of how it is subjectively played out in social interactions and social roles; 2) "direct experience" between peoples of diverse cultures (otherwise the experience becomes merely a cognitive exercise); and 3) the opportunity to reflect on and integrate new learnings based on one's experience. It is in this context that cultural awareness training for the helping professions have taken place at CPCS and that CPCS has institutionalized cultural awareness.

How has CPCS begun to institutionalize cultural awareness? As a competency-based system, the primary method for learning at CPCS is through competencies that are developed as part of the curriculum. In terms of step one of the institutionalization process - the identification of an institutional need - CPCS has tended, from its inception, to be sensitive to the need for cultural awareness. Over the years for instance, the College has developed a number of competencies to address the issue of culture. However, when I was hired in 1979 to teach in the General Center (the liberal arts component of the College), I discovered a set of competencies that tended to reinforce a dualistic approach to understanding culture. The competencies required students to study and compare cultures as if they were static objects. While well intended, the danger with these competencies was that they had the potential for reinforcing cultural stereotypes about groups of people.

To its credit, CPCS maintains a tradition of institutional self-examination, making it relatively easy to set step two of the institutionalization process into motion. The examination process at CPCS takes place through a variety of methods, including curriculum reviews and revisions, ad hoc meetings, faculty/staff meetings, center faculty meetings, and meetings of the governance structure via committees such as the Certificate Council and the Policy Board. A year or two after my arrival, the General Center engaged in a process of reexamination focusing on curriculum revision. I used this opportunity to develop the College's current

cultural awareness competency. At that time, my vision was to have a process for cultural awareness training built into the system in such a way as to minimize the tendency for individuals to make object out of other people and their cultures. The development of this vision, then, represents the third step in the institutionalization process.

The fourth step of the institutionalization process - nurturing the institutional vision - occurred over a number of years. Over the years, the cultural awareness competency was an elective competency in the General Center at the College. As I and other faculty continued to teach this competency or to offer it for evaluation, students and faculty continuously reported the value it had in enhancing their sensitivity to cultural awareness. One student reported, for instance, that she used the competency to approach fellow students from cultures other than her own that she otherwise would not have approached. As she and two other students from different cultures worked on the competency together, they each reported that the interactive process allowed them to better understand and appreciate their own cultural limitations. Another student used the competency to participate in crosscultural events in communities other than her own and to engage in what she initially perceived as a scary interactive process. She reported that she ultimately felt empowered by the process. As more and more students reported similar experiences, the competency became increasingly visible within the institution.

The tone for formalizing the institutional vision (step five) was created both by the above experiences of students and faculty and by a the leadership structure at CPCS. Included in the leadership structure were: 1) the Dean, who supported by modeling an attitude of acceptance; 2) the Director of the Assessment program and the faculty who teach in the Assessment program; they proposed the idea of making the cultural awareness competency a required competency and began to implement the idea; I was one of the Assessment faculty at the time; 3) the Certificate Council, which reviews and approves new competencies and curriculum changes; they proposed the idea of having the cultural awareness competency be part of a set of "core competencies" and to have it linked to other race and culture competencies in the curriculum; this policy recommendation was then sent to the Policy Board of the College; I was also a member of the Certificate Council at the time; 4) the Policy Board establishes overall policy recommendation for the College and the Dean; the Policy Board has approved of the idea.

Currently I teach in the Human Services Center (one of the career components of the College), which has a competency called "Race and Culture in Human Services." This competency requires students to discuss the ways in which racial and cultural factors affect the delivery of human services. In doing so, students examine the interrelationship between the dominant racial and cultural group and two racial and cultural subgroups. It is a required competency for human services majors, but until recently the institutional link between the cultural awareness competency and the race and culture in human services competency had

not been made clear to students. Other career Centers also have developed competencies or are in the process of developing competencies that deal with the issue of race and culture, but again until recently the institutional link between the cultural awareness competency and those other competencies had not been made clear to students. That institutional link is has begun to be established at CPCS. The first step in making the link clear has been the acceptance of the policy that requires all incoming students to complete the cultural awareness competency as part of a required Assessment course at CPCS. Another shift has been to view the cultural awareness competency as part of what are labeled "core competencies." These two steps, therefore, have created the context for cultural awareness being institutionalized (i.e., for being part of the way things ar done) at CPCS. Efforts are also made to offer cultural awareness training to faculty in the Assessment Program who teach cultural awareness competency. In short, step six of the institutionalization process (normalizing the institutional vision) has emerged from an embryonic phase and has taken root at CPCS.

The cultural awareness competency is an attempt to utilize the holistic concept of culture and the principles of crosscultural communication to minimize the tendency to treat people and their cultures as "objects" in an institutional context. Specifically, it is designed to help students develop competence in understanding the culture-in-self and the culture-in-others. The competency actually encourages students to engage in a process of learning about the culture-in-themselves and the culture-in-others. While cognitive aspects are certainly built into the learning process (i.e., the use of reference materials), the process itself encourages self-discovery and discovery about others through face-to-face contact with people from cultures other than one's own. It also invites students to examine cultural beliefs and values that they have internalized and to reflect on how they have used (i.e., accepted, rejected, or modified) these beliefs and values to construct their reality. The are further invited to examine how this same phenomenon has happened for others, in essence, the competency helps the student to become aware of his or her own valid, subjective cultural reality and encounter the valid, subjective cultural reality of at least two people from cultures other than one's own. Finally, the competency also provides an opportunity to integrate any new learnings based on their experience.

The intent of the holistic model and the principles for crosscultural communication is to introduce a new approach that an assist in the development of more effective and more sensitive cultural awareness training for the help professions. Hopefully, the two examples above illustrate how this might be done.

Conclusion

The importance of institutions being sensitive to the issue of cultural awareness became a salient societal issue and examined various models that were developed to respond to the need. Also discussed were barriers to developing cultural awareness and an innovative holistic approach or model, along with some

crosscultural communication principles that reframe a way of understanding cultural awareness. The essence of this reframing is to view individuals and their culture as involved in a constant dialogue through which they define each other. The application of this new approach was then examined in terms of implications for cultural awareness training, some of the work of Interculture, Inc., and the College of Public and Community Services' experiment with cultural awareness training for and helping professions through an institutionalized approach. Steps regarding an institutionalization process were also identified and applied with respect to CPCS's experiment. It is hoped that the discussion stimulated thought for how other organizations, educators, managers, and policymakers might incorporate some of the ideas discussed into their institutional and life settings.

VICTIMIZATION AND TRAUMA IN THE AFRICAN AMERICAN COMMUNITY: A MODEL FOR INTERVENTION AND TREATMENT

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The news media - radio, print, and television - constantly barrage us with words and images of violence and victimization. Often the stories are from far away places with names like Cambodia, Haiti, and Bosnia, where mass victimization is occurring. Other stories are of places closer to us; our country, our state, our community, where the violence may be less organized but no less significant. It is these stories which make clear to us the pervasiveness of violence in twentieth century life. This violence affects each of us either directly or indirectly and is not constrained by the boundaries of race, culture, gender, or socioeconomic status. However, the direct impact of violence and victimization is often felt disproportionately by certain groups and certain communities. Currently, this burden is borne by the urban minority community.

Acts of violence and victimization are experienced as traumatic life events. Traumatic life events can be defined as those events which are so extreme in intensity as to produce psychological distress. These events are generally thought of as falling outside of the range of usual human experience. The African American community has been particularly impacted by the extremely stressful traumatic events which occur with routine frequency. Domestic violence, physical and sexual abuse of both adults and children, robbery, assault, homicide, and other acts of violence occur all too often in this community.

This paper will discuss the impact of trauma and it's manifestations with a particular emphasis on the African American community. Additionally, a treatment model will be discussed with considerations given to cultural variables which impact treatment and recovery.

Trauma and Post Traumatic Stress Disorder: A History

The impact of traumatic experiences has been the subject of research and theories for decades. Pierre Janet (1889) taught that reactions to trauma interfered with information processing, and that the associated hyperarousal was responsible for memory disturbances (van der Kolk, 1989). Janet also hypothesized that trauma caused biological, cognitive, and emotional changes in the victim (van der Kolk and van der Hart, 1989). In the early twenties, Freud also developed a biologically based model, postulating that fixation on the traumatic event led to anxiety (van der Kolk, 1988). Other early pioneers including Pavlov, Kardiner, Spiegal, and Grinker have all made contributions to our current understanding of trauma.

During World War I, as veterans suffered "battle fatigue" or "shell shock," there was an increased interest in post-traumatic reactions (McCann, et al., 1988). At that time, common wisdom held that shell shock resulted from organic factors such as brain lesions caused by carbon monoxide poisoning (McCann, et al., 1988). Interest waned until the next war when reactions to trauma were defined as a syndrome with both psychological and biological components. In 1952, the syndrome was included in the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I), but was summarily dropped from the DSM-II. Since this disorder had come to primarily be associated with war related stresses, we assume that during peace time, the rationale was that it no longer warranted attention.

Of course, the Vietnam war rekindled the interest in trauma. Those professionals working with the veterans noticed not only the severity of their reactions to trauma but that often the onset of symptoms was delayed. In 1980 the diagnosis of post traumatic stress disorder was included in the new DSM-III (Brett, et al., 1988), and revised in the DSM-III-R in 1987.

With the legitimation of Post Traumatic Stress Disorder as a diagnostic category came a new wave of research and refinement, which unknowingly at the time had it's roots in Jenet's early work. With this new-found interest both in the etiology and the diagnostic category itself, mental health professionals began to see the symptom cluster in members of the general population who had no record of military service. As described in the current DSM these symptoms include the following: 1) a persistent reexperiencing of the traumatic event either through recurrent and intrusive recollections of the event, recurrent distressing dreams of the event, reliving the event through delusions, hallucinations, or flashbacks, or through intense psychological distress when exposed to events which resemble or symbolize some aspect of the traumatic event; 2) persistent avoidance of stimuli associated with the trauma by attempting to avoid thoughts or feelings or activities associated with the trauma, being unable to recall important aspects of the trauma, diminished interest in significant activities (in children, the loss of newly acquired developmental skills, feeling detached from others, restricted range of affect, or a sense of a foreshortened future; 3) experiencing persistent symptoms of increased arousal including difficulty falling or staying asleep, irritability with outbursts of anger, inability to concentrate, hypervigilance, hyperarousal, or physiological reactions when exposed to events which symbolize or resemble aspects of the traumatic event (Spitzer, et. al., 1987). From these criteria it is apparent that psychologically traumatic events can impact every aspect of functioning; emotional, cognitive, biological, behavioral, and interpersonal.

Violence and Victimization in the African Community

Unfortunately, the level of violence in the African American community is neither speculative nor exaggerated. The age adjusted homicide rate for non-White males has consistently risen since the beginning of the twentieth century at a much

higher rate than for White males. The results of one recent study indicated that homicide is the leading cause of death among African American males, ages 15 to 34, and that seventy five percent of these victims were either related to or acquainted with their assailant (Griffith & Bell, 1989). In 1986, African American males were six times as likely to be homicide victims than White males, and African American females were four times as likely to be homicide victims as White females (Griffith & Bell, 1989). The increased access to guns has certainly contributed to the lethality of violence in the community. In 1990, the Centers for Disease Control found that from 1984 through 1987, guns were involved in 80% of homicides and accounted for 96% of the increase in the homicide rate for African American men between the ages of 15 and 24 (NCCIP, 1991)

Homicide is but one of many violent crimes affecting the community. Physical and sexual assault, incest, robbery, and arson are others which occur all too frequently. Those who experience the violence directly as well as those who experience it indirectly are all victims, or more appropriately, survivors. The violence is indiscriminate, touching the lives of the young and the old, the firm and the infirm, male and female.

In a study of 1035 school aged African American children conducted in a mid-western inner city, 75% of the boys and 70% of the girls had seen someone shot, stabbed, robbed, or killed (Shakoor & Chalmers, 1989). Twenty three percent of the children surveyed had witnessed a murder with 57% of those being boys and 43% being girls (Shakoor & Chalmers, 1989). Another study of school children in New Orleans found that over 90% had witnessed violence, 40% had seen a dead body, and 70 % had witnessed weapons being used (NCCIP, 1991).

The results of a study of African Americans receiving outpatient mental health services in a major urban area indicated that 80% of those sampled had been the victim of a major physical assault as an adult and 59% had experienced an assault as a child; 37% and 31% respectively, had been sexually assaulted as a child and as an adult (Jenkins, et al., 1989). Looking at these assaults by type and sex, these data reveal that 71% of the women were physically abused as children and 57% were sexually assaulted before age sixteen. Half of the sexual assaults were perpetrated by a family member, 43% by some other person known to the victim, and only 10% by a stranger. For the men, 88% had been physically assaulted as a child while 31% had been sexually assaulted as a child (Jenkins, et al., 1989).

While these statistics give a sobering sense of the prevalence of violence in the African American community, the numbers cannot convey the impact as experienced by members of the community. It is the younger members of the community, the children, the future of the community, who are most vulnerable. There is a growing consensus that children and youths exposed to violence, either as direct victims or witnesses, may adapt in ways that produce developmental impairments, psychological and physical damage, and promote a model of

socialization based on fear, violence, and hatred (Garbarino, et al., 1991; Pynoos, et al., 1990; Terr, 1991).

Much of the violence against children is perpetrated by adults (there are of course child and youth perpetrators), and often by adults from whom children should be able to expect nurturance and protection. When they suffer violence and abuse at the hands of these adults, they experience a sense of betrayal and confusion. Their views about safety, trust, security in human relationships, and even about their own future are radically changed. Further, when we consider the link between trauma, biochemical changes, and behavioral sequelae (Van der Kolk, 1988), we must be concerned about acute symptoms as well as long term consequences.

Impact on Individuals in The Community

The effect of victimization and trauma can effect human functioning on all levels including emotional, cognitive biological, behavioral, and interpersonal. While there may appear to be clear boundaries between each of these domains, the trauma impact is pervasive and highlights the inter-relatedness of function of these domains.

Affective Domain: Children and adults who have been victims of violence, either as direct victims or witnesses, universally experience feelings of fear and anxiety (Terr, 1979, McCann, 1988). While these are normal responses, when considering variables such as developmental stage, premorbid history, and severity and duration of trauma, the feelings may become overwhelming for both children and adults. Therefore, in response to the possibility of being overwhelmed, defense mechanisms are developed. These defenses may be primitive such as avoidance, distancing behavior, denial, projection, and splitting.

Observations of abused infants and toddlers in hospital or therapeutic nursery settings indicate that they frequently avoided all eye contact, avoided physical contact with their mothers, and had periods of "frozen watchfulness" and hypervigilance (Green, 1983). Denial that the traumatizing event has occurred, or is occurring, is common. When the perpetrator is a parent, the child may not only deny that the parent committed the act, but may displace the malevolence onto someone else or onto him/herself. This allows the child to hold on to the fantasy of having a good and loving parent. In extreme situations, the victim may psychologically remove him/herself from the traumatic episode through the process of disassociation. Use of this defense allows the victim to live through the trauma as if it were happening to someone else.

Depression is another emotional response to trauma, but will differ slightly in manifestation in children and adults. Adult victims may display more "classical" symptoms of depression including loss of appetite, sleep disturbance, sadness, fatigue, difficulty in concentrating, and morbid thoughts. Children may experience many of these symptoms but instead of appearing "depressed" may become

suddenly gregarious and outgoing. Most notably, depressed children may begin to engage in risk taking behavior.

Anger is yet another affect commonly experienced by victims of trauma. McCann (1988) notes that rape victims report experiencing an increase in feelings of anger and hostility for up to a year after the rape. Anger and a desire to blame someone seem to be reasonable responses to acts of violence. However, many victims, particularly children, may have no safe or appropriate channel for acknowledgement or expression. For these victims, anger may become a focal behavioral determinant.

Biological/Cognitive Domain: Fear and anxiety are commonly associated with arousal of the autonomic nervous system including increased heart rate, blood pressure, and respiration (McCann, 1988, 1989). Van der Kolk (1988) hypothesizes that inescapable shock caused by the traumatic event produces biochemical changes in the brain which leads to chronic hypersensitivity to stressful stimuli. With this condition, the victim's decreased capacity to modulate physiological arousal impairs the ability to cope with stress (Van der Kolk, 1989). During the experience of the actual traumatic event, the victim's autonomic nervous system becomes highly aroused. In this state of arousal, memory tracts of the event are laid down which will profoundly influence later actions and interpretation of events. Visual and motoric reliving of the event, nightmares, flashbacks, and re-enactments result from activation of the memory tracts (Van der Kolk, 1989). Additionally, the chronic state of hyperarousal may lead to an increase in somatic complaints such as muscle tension, immunosuppression, headaches, and gastrointestinal disturbances among many others.

In the state of constant hyperarousal, receptors in the brain which ordinarily are available to process information about the environment are overinvolved in detecting danger (Green, 1983). This means that the ability to take in and synthesize information and to use it to make rational decisions governing behavior is impaired. What results is impulsive behavior with little or not consideration of consequences. Green (1983) also notes that hypervigilance is associated with speech and language disorders, and for some victims of child abuse head injury accounts for cognitive deficits.

Behavioral/Interpersonal Domain: Since behavior is observable, it is in this domain that we are able to "see" the impact of trauma and the interrelatedness of the various domains. The fear, anxiety and depression noted in the affective domain are often behaviorally manifested. For example, both child and adult trauma victims may become withdrawn and reclusive. Children may not want to or feel able to leave their homes resulting in truancy, falling behind, and ultimately dropping out. Adults may take extended time off from work, using up benefits and often losing employment. Anxious children may lose their sense of mastery and autonomy, and even regress developmentally. These children may lose previously achieved bladder and bowel control, further damaging their sense of self esteem

(NCCIP, 1991). These children may demand increased parental attention and may want to sleep with parents. In many homes where space and privacy are already scarce these demands will exacerbate familial tensions.

In one case seen at the Trauma Clinic, a single, African American mother brought in her six year old son who had found the body of a slain relative. The child had become clingy and sullen, and had refused to attend school, citing a host of somatic complaints. From the time of the event, the child had been unable to fall asleep in his own bed and had been sleeping with his mother. The mother, who was in a job training program had no one to consistently leave the child with during the day, had begun to miss days from the program. Additionally, the boy had begun to demonstrate previously unseen anger and hostility toward the mother's boyfriend. Here we see that the impact of trauma is not contained in a single source but has a ripple effect, touching others who may come into contact with the victim.

Adult victims may find other methods of dealing with their fear and anxiety. Self-medicating or substance abuse often becomes the chose, method. The availability of a variety of drugs in the community, both legal and illegal, make the attempts to self-medicate an easy option, even for those with no previous history of substance abuse. Ironically, since many acts of violence are committed by those involved in the use of alcohol or other drugs, it seems that a cycle of victimization is perpetuated with the victim becoming the victimizer. There is much evidence that perpetrators of incest, rape, child molestation, and domestic violence were victims themselves or witnessed violence in their homes as children (Dutton and Painter, 1981; McCann, 1988).

Anger is another trauma related affective state which has a dramatic impact on behavior and interpersonal relationships. When the factors of hyperarousal and the resultant impulsivity combine with feelings of anger and rage of many victims, the mixture is volatile. Add to this the disinhibiting effect of alcohol or other drugs, and the frustration that many African Americans feel as a result of racism and the potential for violence increases exponentially. All too often, the targets of this anger are the innocent or at least those who had nothing to do with the original victimization. All too often, in the African American community, the victims are other African Americans.

Given this information, it is not surprising that trauma has an impact on interpersonal relationships. Relationships are based on trust and trauma victims, depending on the developmental stage at the time of the trauma, either never learned to trust or had their notions about trust destroyed. For these victims, getting close to someone or allowing someone to get close to them is a frightening prospect. Victims' reports of impaired sexual functioning is frequent. Victims of rape and childhood sexual abuse report problems including fear of sex or arousal, and decreased responsivity and satisfaction (McCann, 1988). Other victims of childhood sexual abuse may be precocious and inappropriate in their behavior.

Victims of violence most often feel powerless to stop or prevent their victimization. This feeling of powerlessness endures long after the event(s) are over, but become no less intolerable. The conscious need to master the trauma and feel powerful can be quite a strong motivator of behavior. Concurrently, Van der Kolk argues that stressful events cause the production of endogenous opioids which act as a type of analgesic much like morphine (Van der Kolk, 1989). Reexposure to trauma then results in a decrease in anxiety and hyperarousal. Each of these explanations gives some insight into the behavior of some African Americans. After being victims of violence or witnessing violence in the home, in school, and in the neighborhood, many young men perpetrate heinous acts of violence. These behaviors are not limited to men nor to the young, and no matter what the cause, the impact on individuals and the community is devastating.

Violence and victimization has reached epidemic proportions in the African American community and everyone is exposed. This epidemic is leaving a blight of fear, anxiety, lack of trust, impaired cognitive functioning, substance abuse, and lasting personality changes (Shakoor and Chalmers, 1989). Poverty and racism reduce the choices for healthy adaptation and foster the inter-generational transfer of patterns of victimization.

Intervention and Treatment

Since its inception in 1984, the Trauma Clinic has been guided by the mission of exploring the impact of overwhelming life events on the psychological development and well-being of children and adults. The clinic provides services to those who are acutely traumatized as well as those suffering the effect of long term or chronic trauma. Interventions are provided to individuals, couples, families, and entire communities. The clinic has attempted to reach those in communities disproportionately affected by violence, working with the police, district attorney's offices, battered women's shelters, DSS, the Massachusetts Office of Victim Assistance, DMH, schools, community leaders, and others.

The Trauma Clinic provides mental health services to a very specific portion of the population and therefore differs somewhat from the community mental health centers. All clients receive a standardized two to four session evaluation using structured interviews as well as at least three trauma specific assessment tools. However, the assessment does not simply consider the individual as he or she presents, but incorporates the concept of contextualism. This enables the therapist to see the client as part of a multidimensional, interrelated system. From this perspective variables such as family, both current and past, values, race and culture, relationships, and social and economic functioning all help to define who the client is and what interventions might be helpful. During the assessment phase, psychoeducation about the nature of traumatic experience begins. As treatment begins, psychoeducation continues with the goal of helping the clients to understand that their reactions to the traumatic events are predictable and that

many of the sequelae grew out of attempts at adaptation and not self-induced pathology. This knowledge usually offers significant relief from the anxiety.

Following the completion of the assessment phase, a treatment plan is developed incorporating both clinical and contextual data. Treatment proceeds only after the plan has been presented to the clinical team and approved. Treatment is conceptualized as taking place in stages: stabilization, recovery, and integration. Stabilization involves focusing on maintaining or regaining the ability to function adequately in the day to day world. Referral for medication to decrease symptoms such as anxiety, depression, flashbacks and nightmares which impair functioning, may be made during this phase. Recovery involves dealing with and resolving the feelings associated with the trauma. Integration is a phase in which the client integrates the meaning of the traumatic experience for him/herself and is able to move past the trauma and go on with life.

Another service offered by the clinic involves community based intervention. When traumatic events deeply impact an entire community, clinic staff is available to travel to communities and provide community based debriefings. All members of the community are invited to the debriefings, which are coordinated jointly with the community leaders. Debriefings are structured to bring the community together in a time of tragedy to share factual information about the trauma, to provide psychoeducation, to allow people to discuss and deal with feelings related to the event, and to help develop strategies for long range coping. Throughout, the goal is to empower the community and leave them with a sense that they can help themselves. Additionally, during or after the debriefings, individuals at risk are identified and referred for treatment.

Theories of psychological trauma do not explain all the problems in the African American community, or any other community either. Nor do the interventions and treatment offered at the Trauma Clinic purport to solve all of the problems. However, it is clear that many people in the community are being victimized and traumatized daily. Interventions such as those offered by the Trauma Clinic can be useful, but much more is needed.

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PSYCHOTHERAPY OF ASIAN AMERICANS

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Abstract:

Asian Americans are a heterogeneous group. Psychotherapy of Asian Americans must take into consideration their varied cultural backgrounds, educational and immigration experience in the U.S., and the degree of Western acculturation.

Based on their experiences in treating Asian American patients in the Greater Boston area and a review of literature, the authors will describe some common sociocultural themes in the illness experience of Asian American patients and suggest ways of optimally engaging them in psychotherapy.

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Psychotherapy of Asian Americans

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I. Introduction:

According to the 1990 census report, there are 7.3 million Asian Americans[1] in the U.S. (1) The number of Asian Americans has doubled since the past decade and Asian Americans are now recognized to be the fastest growing minority group. (2) With 143,000 Asians, Massachusetts now ranks 10th among the states with the largest Asian and Pacific Island population in the nation, a rise in rank from 13th ten years ago which represents a 190 per cent growth rate. (3)

Asian Americans may be the most diverse minority group. Six groups of a half million or more (Chinese, Japanese, Filipino, Asian Indians, Vietnamese, and Koreans) constitute 84% of all Asian Americans in the nation. The fact that immigration accounts for much of the population growth among Asians during the 1980s adds to its diversity.

Therapists who treat Asian patients must recognize their diversity. Although they may share certain overlaps in religious beliefs and cultural values, Filipino, Chinese, Indochinese, Japanese, Korean, Asian Indian, each has very distinct cultural traits and unique historical experience. These groups also differed in their immigration experience to and settlement in the United States. For example, Japanese Americans were put in concentration camps during the Second World War. Indochinese Americans are the most recent Asian immigrants and are primarily refugees.

Depending on their educational and social backgrounds, their ability to speak English and length of residence in the U.S., each wave of Asian immigrants are acculturated in varying degrees into the American society. Thus, traditional health values, beliefs and coping styles about health and illness which they brought with them may accordingly be modified. In general, the more acculturated they are, the more they tend to accept Western modes of therapy and treatment, including psychotherapy.(4)

Based on a review of literatures and our experience in rendering psychiatric care to Asian-American patients in the Greater Boston area in the past 15 years, we shall describe certain sociocultural themes which should be taken into consideration when engaging Asian Americans in psychotherapy.

II.   Engagement of Asian American Patients in Psychotherapy:[2]

Kim (5) has outlined several steps in the engagement of Korean American patients in psychotherapy which we feel are generally applicable to most Asian American patients.

1. Accepting the patient's inner reality

The first step in psychotherapy of Asian patients is the acknowledgement of the validity of their inner reality such as their fears, shame and concern of stigma of mental illness. The patients must feel that the therapists understand and accept their concern as well as that of their family. Seeing a psychiatrist or a therapist may imply "being crazy" for many Asians. It is important for therapists to be sensitive to these feelings, and to recognize how these feelings may be expressed in terms of initial "resistance."(6). Therapists should explain what the therapeutic engagement entails, how confidentiality or their limits may be maintained. It is equally important to educate the patients and their families on the nature of the psychological problems and the rationale of diagnostic and therapeutic procedures.

2. Countering shame

To be labeled mentally ill has implications not only for the Asian American patient, but also for the entire family as well. It raises concern about the marriageability of the patient, other family members and their off-spring. It affects the family name and reputation. It is therefore important for therapists to empathize with the patients and their families around their sense of shame, helping to verbalize feelings, reassuring them with medical facts regarding genetic information, and maintaining confidentiality. For Korean Americans, S.C. Kim also pointed out the usefulness of reframing help-seeking behavior as consonant with maintaining the family's good name by the patients' courage to go beyond cultural bias and inhibition against seeking necessary care. (7)

3. Understanding "resistance"

Initial difficulties in developing trust, hesitancy in opening up, and a tendency to give limited information may be related to Asian cultural values of being "reserved" as a sign of maturity and self-control. It takes time for therapists to determine what is personal and cultural and a patient's behavior. Therapists should allow time for trust to develop and to be alerted to the opportunity of disclosure of additional information as therapy progresses.

4. Somatization

Somatic expressions of psychological distresses is often a culture-syntonic way of dealing with emotional conflicts for Asians. (8) As symptoms may also represent signals of true somatic illnesses, and to show that the therapists are not ignoring the

patients' complaints, therapists should always take a good medical history and refer to proper medical specialists for clarifications of diagnoses, differential diagnoses and treatments when questions arise. Such acts are not only sound medical practice but also a way of reassuring the patients and their families that the therapist is "listening" to their concerns. It helps to establish trust and rapport.

When dealing with interpretation of somatization symptoms, we propose a process of "approximation" that begins at the level of the patients' manifest complaints and gradually move to uncover deeper psychological meaning. This process takes time. Therapists should not rush into premature interpretations of symptoms. Familiarity of certain folk medical terms or notions of an indigenous concept of health and illness, as in "hot and cold" concept of health, illness and properties of food, or the notion of "Hwa-byung" (Fire Illness) among Koreans (9) and "Shen-ching shuaijo" (Neurasthenia) among Chinese (10) can assist in explaining the interrelationship of psychic distress and somatic symptoms.

5. Establishing authority and being directive

Asian culture is based on a patriarchal, vertical, and hierarchical system of authority. A high value is placed on respecting authority figures. Confucian ethics prescribe clear roles of relationships between rulers and subjects, parents and children, males and females and among friends. In a traditional medico-philosophical system of healing such as the Chinese traditional medical practice, the healer is expected to know what is wrong with the patient and the correct way of rectifying it. Being "directive" means that the physician or the therapist be willing to take charge, assume authority and responsibility, and exercise his or her expertise wisely and benignly.

6. Multiple roles of the therapist

Studies have shown that Asian-American patients are reluctant to use mental health services. (11) Coping with mental illness is usually first confined within the family, then to some trusted relatives or friends, and finally, when all means are exhausted, referral to a professional. Thus, when an Asian patient comes for psychiatric care, the individual and familial resources may frequently be exhausted. The patient may be beset with multiple problems: physical, familial, psychological, social, legal, and spiritual. The therapist frequently is called upon not only to act decisively, but to assume multiple roles such as being a diagnostician, educator, advocate, case coordinator, individual and family therapist, mediator, etc. Assumption of such multiple roles often challenge the skills and dedication of the therapist. There is a lack of role model. There is also the constraint of time and limited monetary reimbursement.

7. Working with the family

Because of the centrality of the role of the family, the family is frequently involved in the evaluation and in the treatment process of Asian American patients, including the selection of treatment modality. The prevailing American values of individual independence and respect for individual confidentiality may at times be at variance with the Asian value of interdependence and mutuality of relationships. The therapist must strike a balance in respecting both the need for confidentiality of the patient and the need of the family to be informed and be involved.

We encourage therapists to include the family in therapeutic decisions as much as possible. Regular family meetings can be explained as an effort to review progress and to obtain feedback from the family. Such efforts are usually appreciated by both the patients and their families.

8. Psychotropic medications and concurrent use of herbal medicines

Asian patients are generally receptive to use of psychotropic medications. However, there are reports that Asians may require lower dosages of psychotropic medications and that they may show more propensity to adverse drug reactions. (12) Nonetheless, because of differences in body weight and body fat content between Asians and Caucasians, drug dosages generally prescribed for Caucasians may be too much for Asians. It is prudent to start drug dosages at a lower level for Asian Americans. The potential benefits and adverse action of drugs including remedial measures must be carefully explained to both the patients and their families.

As Asians have long experience with their own traditional and folk medical practices, it is not unusual for them to simultaneously take Western and herbal medicines. Western medicines are believed to be effective for acute illnesses but can cause more side effects. Herbal medicines may be thought to "invigorate" and "strengthen" their stamina. Besides, the patient may want to take advantage of what the "best of two worlds" can offer.

We have no objections to patients taking both kinds of remedy. However, we routinely caution them that it is better not to simultaneously take Western and herbal medications since drug interactive effects between the two category of drugs are generally unknown.

9. Eventual goals of psychotherapy

Psychotherapeutic goals usually reflect prevailing cultural values. Joe Yamamoto and his colleagues have eloquently pointed out the difference between the cultural values of American and Japanese civilization. (13) What should be the ultimate therapeutic goals for Asians? Is it the promotion of independence from the family or the achievement of interdependence? Should it be an emphasis on

individual achievements or group achievement? These are complicated issues and require further comparison of experience and research. We do want to raise them to sensitize therapists not to automatically impose Western values on Asian American patients, but to take time to work these out with them.

III.   Conclusion:

Asian American patients are a diverse group and each group has different cultural traditions, values, beliefs, and experience of immigration to and settlement in the U.S. society. Therapists providing psychotherapy to Asian American patients must recognize their diverse experiences. By paying attention to how cultural sentiments influence Asian American illness experience, psychotherapy with Asian Americans can become a mutually satisfying endeavor for both the patient and the therapist.

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Footnotes:

[1] Asian Americans refers to United States citizens of Asian ancestry who reside permanently in the continental United States, Hawaii, and U.S. Pacific Territory islands. The U.S. Census currently tracks the following Asian groups: Japanese, Chinese, Filipino, Korean, Asian Indian, Vietnamese, Hawaiian, Guamanian, Samoan, and other Asians.

[2] The outline and most of the material in this section are drawn from Kim, L.I.C., *Psychiatric Care of Korean Americans*, in Gaw, A.C. (ed), Culture, Ethnicity, and Mental Illness, American Psychiatric Press, Inc.: Washington, D.C., 1992.

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IS CLOZAPINE UNDERUTILIZED

IN THE MINORITY SCHIZOPHRENIC POPULATION?

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Abstract

Clozapine is a novel antipsychotic agent that selectively blocks mesolimbic dopamine receptors, causes fewer extrapyramidal symptoms than other neuroleptics and has superior efficacy in some patient. Approximately 30%-50% of treatment refractory schizophrenic patients improve with clozapine. Clozapine has been determined to be cost effective as it greatly reduces the number and length of hospitalizations.

Like many advances in modern medicine, clozapine has been slow to reach the minority population. This study determined the percentage of patients on clozapine in the state of Massachusetts as of January 1993 with regards to race. These percentages were compared to the estimated number of schizophrenics within these populations for the state of Massachusetts. The study found that minority treatment-refractory schizophrenics were significantly less likely to be on clozapine than White patients (df=4, t=52.40, p<0.001). The goal is to advocate for a wider use of clozapine in the minority populations as it is underutilized.

Is Clozapine Underutilized
in the Minority Schizophrenic Population?

David C. Henderson, M.D.

Historically, psychosocial and biomedical research about racial and ethnic issues were often used to support prevailing concepts in racial inferiority (1). There has been ample documentation of the pervasiveness of racism in early psychiatric research. Freedom from slavery or racial integration were reported to increase psychopathology among Blacks. The data supporting these claims did not survive close scrutiny and were sometimes found to be fictitious (1,2). In the early 20th century, endocrinological, neurological, and anatomical findings of racial differences were often interpreted as a sign of Black inferiority (3,4).

Schizophrenia was thought to be more prevalent among Blacks, Hispanics, and Asians. However, when standardized diagnostic systems are used, these populations do not differ from Whites in prevalence of most psychiatric disorders (1). More recent studies focused on the symptoms of schizophrenia and suggested that differences occur in symptoms or expression of illness, not in the diagnosis. Griffith found no differences between Mexican-Americans and Anglo-Americans in the disorders they studied (5). Several studies have shown no differences between Black and White subjects in rates of depression, schizophrenia, anxiety, and personality disorders (6,7,8). Fabrega and colleagues found differences in the symptoms associated with schizophrenia and depression between Blacks and White patients. These differences were attributed to alternative forms of expression of psychopathology (6,9). Spurlok suggested that while the prevalence, and perhaps the nature and structure, of symptoms are not influenced by race, the content may well be (10).

Research shows that Blacks and other minorities are at a greater risk of being misdiagnosed compared to Whites. An increased likelihood of hallucinations in Black and Hispanic patients with bipolar affective disorder may contribute to the misdiagnosis of schizophrenia (1,11,12,13). Many studies were not controlled for socioeconomic status, sex, age, education, and therapist ethnicity. Other factors contributing to ethnic differences include misdiagnosis or attribution of symptoms of one disorder to that of another; stereotyping, or associating a typical diagnosis or set of symptoms with a particular group; bias in diagnostic tools against non-English-speaking clients; failure of some client to use mental health services until illness is severe, and differences in expression of psychopathology; and misdiagnosis of cultural phenomena as illness (6).

The prevalence of schizophrenia is now considered to be 1% of the population. Of this, studies have shown between 5-25% prevalence of treatment-refractory schizophrenia (14). Treatment-refractory schizophrenia in the past has been a major clinical problem requiring more intensive care and having persistent disabilities. Clozapine is an atypical antipsychotic agent that selectively blocks mesolimbic and mesocortical dopamine receptors and is effective in 30-50% of schizophrenics who do not respond to conventional agents. Clozapine is unlike conventional antipsychotic agents in that it does not produce extrapyramidal symptoms such as parkinsonian syndromes, dystonia, and tardive dyskinesia (15,16). Clozapine is not without side effects as approximately 1-2% of patients in the United States develop agranulocytosis and 1-5% develop dose-dependent seizures. The risk of agranulocytosis is greatly reduced by careful monitoring of white blood cell counts. An increased risk of agranulocytosis has been associated with HLA-B38, DR4, DQw3 in Ashkenazi Jews and Pfister et al. reported one case of agranulocytosis with HLA-B39, DR4, DQw3 in a Native American (17,18). Benign neutropenia seen in healthy adults, particularly Blacks and Yeminte Jews, is not a contraindication for clozapine. Also at higher doses, the risk of seizures can be prevented by adding anticonvulsant medications such as valproate(19). Clozapine represents a significant improvement in how treatment-resistant schizophrenia is treated. The goal of this study is to determine whether clozapine is being used equally in non-White and White schizophrenics.

Methods: Data was obtained from the Clozaril National Registry concerning the total number of patients on clozapine in the state of Massachusetts by race as of January 1993. Data from the 1990 Census of the Population of Massachusetts by race was also obtained. Racial or ethnic group identity was designated by White/non-Hispanic, Black/non-Hispanic, Latino/Hispanic, Asian/Pacific Islander and other which included Native Americans. Ethnicity was categorized for analysis as White, Black, Hispanic, Asian, and other. From the Census data, the estimated number of patients on clozapine were determined based on the percentage of the population by race. Data were analyzed by a Chi-Square Test.

Results: The total number of patients on clozapine in the state of Massachusetts in January 1993 was 2866. The racial or ethnic identity of 344 patients were unknown and therefore eliminated from the analysis. Minority treatment-refractory schizophrenic patients were significantly less likely to be on clozapine than White patients (df=4, t=52.40, p<0.001).

Whites represent 87.96% of the population in Massachusetts and 91.40% of the patients on clozapine. Blacks represent 4.56% of the population and 4.72% of clozapine patients. Hispanic represent 4.59% of the population and only 2.22% of patients on clozapine. Asians represent 2.31% of the population and only 1.03% of the patients on clozapine. Finally, Native Americans and "Other" represent 0.6% of the population and 0.6% of clozapine patients. (See Table 1.)

An unsuspected finding is that clozapine may be underutilized in treatment-refractory schizophrenia. Based on the estimate that 5-25% of schizophrenics are treatment-refractory, this represents from 3,000-15,000 patients. If 15,000 patients is more accurate, this would indicate clozapine is underutilized throughout the state of Massachusetts.

Discussion: Like many advances in modern medicine, clozapine has been slow to reach the minority population. Minority treatment-resistant schizophrenic patients are significantly less likely to be on clozapine and clozapine may actually be underutilized in all schizophrenic populations in the state of Massachusetts. There are a number of factors that may be involved in this. Hispanics and Asians achieved less than 50% of their expected clozapine patients. This finding suggests that a language barrier may prevent these populations from receiving the appropriate treatment. If bilingual clinicians are not available, interpreters need to be provided as well as training in cultural issues. Access to treatment may be limited by perceived or real unavailability of clinicians.

Minority schizophrenic patients are frequently felt to be more violent, though studies have shown that this is not the case (20). Significant negative symptoms of schizophrenia are generally considered a more severe aspect of the illness. However, if a clinician fears a patient, or population of patients, are more prone to violence, severe negative symptoms may be acceptable. Severe negative symptoms is an indication for clozapine.

There are limitations to the study. There were 344 whose race was unknown at the time of the study. This could potentially change the significance of the data. Also, the 1990 Census data may not actually represent the current racial make-up of the state. Though, it is estimated that the minority population is continuing to increase.

Clozapine needs to be made available to the minority schizophrenic population. For the predominantly White clinics, training programs on ethnic minority cultural issues and interpreters should be provided. For predominantly minority clinics, where resources are historically reduced, state of the art medicine and training need to be made available. Mental health staff of all racial and ethnic backgrounds should be trained to be aware of their racial biases so they are able to better care for individual patients.

Table 1

Data on Clozapine Patients and the Population of Massachusetts

Race	Mass. Pop.	% Mass. Pop.	Clozapine Patients	% Clozapine Patients	Estimated Cloz. Pts.
White	5,291,918	87.96	2,305	91.40	2,218
Black	274,269	4.56	119	4.72	115
Hispanic	275,859	4.59	56	2.22	116
Asian	139,031	2.31	26	1.03	58
Other*	35,348	0.59	16	0.63	15
Unknown			344		

*Includes Native Americans

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FROM ABSTRACTION TO INCARNATION:
UNDERSTANDING SEXUAL TRAUMA IN CULTURAL CONTEXT

Carlos A. Hoyt Jr.

> Recognition of a common susceptibility to humiliation is the only social bond that is needed.
>
> Richard Rorty

In the final analysis the subject at hand is: vulnerability and response to, and treatment of, trauma in the organism homo sapiens. Specifically, the focus in this article is on sexual trauma in Black children. The first is the issue in the abstract. The second is the issue incarnate. This article proceeds from the principle that any attempt to treat of the latter without proper reference to and appreciation of the former is myopic and potentially counterproductive. Regarding the matter of working with sexual abuse in Black children this article is an attempt at demystification and edification. What needs to be demystified is the prevalent, awkward and hollow notion that psychotherapy with Blacks entails the recognition and negotiation of a unique <u>culture</u>, native to the fortunate Black clinician, possibly perilously foreign to the White clinician. Following the attempt to debunk the illusory notion of Black "community" and "culture," differences of substance and significance which should be appreciated and addressed in work with Black clients (specifically Black children) will be explicated.

In an article entitled "The Emergence of a Black Perspective in Counseling", the author notes that

> Scholarly concern with the process of counseling the Black client can be traced readily to the 1940's when, for example, the workers in the field were disturbed and uncertain about certain aspects of counseling Black youth and adults. (Williams, 1949 in Jackson, 1979)

The upshot of this concern has been an enterprise characterized by endeavors to illuminate "Black culture", the "Black community", the "Black perspective", the "Black experience", and so on, and to give advice, and a goodly share of admonishment, to the predominantly White practitioners of mental health. As a Black psychotherapist with experience across the various spectrums of pathology, age, sex, ethnicity and race, I suggest that this enterprise has produced more heat than light. In other words, the well-intentioned, and worthwhile endeavor to develop cultural sensitivity in working with Black clients has been largely a <u>political</u> enterprise rather than a <u>clinical</u> one.

In the existing literature which concerns itself with addressing the special aspects of work with Black clients, along with useful and valuable information, one can find such alienating and utterly romantic pronouncements as

> Left-brain dominance is fostered in the Euro-American culture, right-brain perception in the Afro-American. ...The emotional and open character of genuine Black expression may seem uncontrolled and "primitive" to many Whites. Blacks on the other hand find the code-of-conduct in White society to be stifling and false, a facade that covers real intentions from both the actor and the observer. The White therapist can quickly become overwhelmed by the intensity of rhythm emanating from the Black client. (Martin and Grubb, 1990)

Elsewhere one can find clearly confused, if also deliberate, mingling of political agenda with efforts to achieve clinical sensitivity.

> ...the genuine need is [for] a synthesis of the emerging Black perspective in counseling. ...this outlook is derived from a sense of Black culture and focusing on means of liberating Black people. (Jackson, 1979)

There is great danger in the above examples of misguided attempts to promote sensitivity in clinical work with Blacks: Danger in employing a heavily loaded term such as "liberation" in the context of a discussion about counseling. These dangers exist for the White therapist who cannot be less than alienated and possibly confused by such remarks; for the Black therapist who is at risk of becoming inducted into this sort of specious pseudo-clinical mode of thought, and, most regrettably, for the Black client who will likely receive less than sound clinical treatment, if treated by any ill-advised therapist (of any color) who subscribes to such wrong-headed beliefs.

The proper clinical treatment of cultural sensitivity in therapy does not involve the romanticizing, politicizing, nor philosophizing of the subject. Instead the approach is analytic, dispassionate, and if not "objective", then detached from any interest save the fundamental interest of psychotherapy: helping individuals negotiate, manage, or resolve the psychic intra- and interpersonal problems they encounter throughout their lives. Understanding this approach requires an understanding of the key concepts involved in the issue of cultural sensitivity in sexual abuse. These concepts are: <u>Clinical Approach, Empathy, Trauma,</u> and <u>Culture</u>.

Clinical Approach

"Clinical Approach" denotes a posture of analytic, dispassionate and impersonal observation and treatment. To take up a thing clinically means to abstract it from its possible moral, social or political values, and to see it instead in terms of its function, impact and meaning relevant to the person being affected by it. Clinical psychotherapy, at bottom, involves the observation and treatment of

symptoms of distress, dysfunction, and disease as they manifest themselves in a person's life. Treatment becomes differential according to how symptoms and dysfunction are manifested (incarnated), but at the crucial level of psychological distress, dysfunction, disease there is no color, nor sex, nor age, nor ethnicity; there is no socioeconomic status..., no exclusive particularization whatsoever. All people are vulnerable at this abstract level, and all who care to help them are capable of having some positive effect. This is not to be confused with a naive "color blindness" philosophy. The prescription here is not to ignore or disavow manifest differences such as race, sex, class, etc., but to establish as the starting place of and axis of reference for one's work a view that transcends myopic visions and affords sight of the matter at an abstract and universal level. Oppression is oppression, discrimination is discrimination, hatred and degradation are hatred and degradation after all, no matter the variables of race, sex, class... which give them incarnation.

Empathy

Empathy comes from the German Einfuhlen _ to "feel" or, more accurately, to "find" one's way into another's experience. Practically speaking, empathy means that the therapist does not simply take a patient's words at face value but looks for the deeper meaning of what the patient is saying, or not saying, in the affective signals that the patient is often unwittingly, transmitting... (Basch, 1988)

To be able to discern the volumes of information communicated in another's silence, or register the sense of impotence and nonbeing contained in a violent rage require the skill of empathy. Empathy is the skill of abstracting essential meaning from incarnate affect. Empathy is not sympathy. One may or may not feel pity for one's client, but to be effective one must be able to be empathetic. While it might seem natural that the closer one is to a client's experience, the more readily one could achieve empathy, this is not necessarily so. Indeed presumptions, conscious or unconscious, about the similarity between a client's and one's own experience can lead to misinterpretations, frustration for the client, and possibly, ultimately, empathic failure. The filter of personal experience is a filter which can be misapplied with harmful effects. Conversely, one might feel repugnance and an inability to relate at all to a client's actual experience, yet this need not preclude an empathic connection being made on the crucial abstract level of what the given experience truly signifies for the client.

Trauma

"Trauma" is a concept akin to "clinical approach" and "empathy" in that in its essence it has universal and unrestricted currency for any human being. Before it takes a manifest, incarnate form in one or several of myriad psychological insults and pathologies experienced by a particular individual, trauma, in the abstract, is an equal opportunity psychological phenomenon discriminating against none and threatening to all. Before the particular, specific incarnation of sexual trauma as it effects Black children is taken up, trauma in the abstract must be apprehended.

A trauma is a "wound", an injury marked by a malfunction. In psychological terms, a trauma signifies the failure of healthy defenses under the strain of overwhelming anxiety and/or stress. As with the registration of psychological trauma, the results may vary widely depending on a combination of constitutional vulnerability and resilience in interaction with contextual risk and curative support. In physical terms, we know that a similar blow suffered to the leg of two different people will have differing results depending on the original health and strength of the victim and her access to services and support that will help the healing process. A healthy and physically robust person immediately cared for and able to properly rest the injured limb may recover and be virtually as good as new. An unhealthy person, physically weak, and unable to rest the injured limb, nor access the services necessary to its proper mending, may forever be disabled. Indeed, regarding the matter of what registers as trauma, the first person receiving the same forceful blow may not even suffer an injury as serious as the second - bruise vs a break, for example.

In psychological terms this translates to the differences in mental health among different individuals and the differences in support which individuals may access. It is well known that what is distressful to one person might be merely manageable stress for another. Likewise, distress properly treated can be alleviated, whereas distress unrelieved can lead to personal disaster. What is not variable is the truth that every person has her threshold beyond which trauma will register and pathology will develop if untreated.

Culture

It is at the level of discussion of "culture" that the other three concepts, clinical approach, empathy, and trauma, gain incarnation. The establishment of the most effective clinical approach, the information necessary to achieve empathy, and an accurate assessment and treatment of trauma depend on apprehending and appreciating the cultural context(s) in which the client exists.

A useful definition of culture is: "everything that is not natural (in nature) human behavior - it is everything a group does that is not innate." (Martin and Grubb, 1990) Eating is not cultural, as all humans eat, but eating with one's hand versus silverware or chopsticks are culturally determined. Family is not a cultural phenomenon in and of itself, but the structure and function and interactional manner of families vary from culture to culture. Aggression is natural to the species (Steele, 1985), but the amount of aggression condoned, and the manners in which it is appropriately expressed are significantly governed by culture. Regarding the matter of trauma, as was stated above, our perceptions and registrations of events and experiences have much to do with our natural constitutions, our "hardware", so to speak, but how we interpret the world and the different stimuli which comprise it depends greatly also on the "software" of cultural conditioning and context.

It has been written, and is certainly true of culture, as it is of individuals, that

(1)   All cultures possess certain behaviors common with every culture,

(2)   Some cultures share certain behaviors with other like cultures, and

(3)   Certain cultural behaviors are unique to each culture. (Martin and Grubb, 1990)

This being the case then, to the extent that there are unique characteristics of the Black or African-American culture, it should be determined which of them might have significant impact on the risk for, reaction to, and availability for treatment of sexual trauma. This, of course, begs the question: Is there a Black culture?

I suggest that while there are existential corollaries, correlates of circumstance, that go with being Black in this society, the notion of there being a Black culture is limited in its usefulness and limiting in its use. Black as a cultural rubric is analogous to White as a cultural rubric. In considering the latter, one may speak in broad and general terms about class or privilege within society, or geographic distribution, levels of education, family make-up, rates of incarceration, etc., but any intelligent and meaningful discussion of White "culture" must quickly and naturally reduce to discussions of the genuine ethnocultural groups which are categorically subsumed under the umbrella "White" (Irish, Italian, Scottish, Anglo-Saxon ...).

As it is with the notion of a "White culture" so it is with that of a "Black culture". Beyond demographical correlates, any substantial discussion of culture among Blacks must become a consideration of African, or African-American, or Haitian-, Dominican-, Costa Rican-American, and to be of any substance must explore the customs, beliefs and traditions of each of the separate and complete ethnic groups categorized under "Black". It is unfortunate, even if it is understandable, that the expeditious use of a superficial identifier which originated in the slave trade should have worked its way so insidiously and firmly into the mindset of our society, and that it remains there still, standing for more than it actually can, and concealing real and valuable knowledge beneath its shroud.

In being culturally sensitive then, in working with sexual trauma in Black children, the client's skin color should not alert the clinician to be on guard for natural rhythm emanating from the client, nor should the clinician struggle to appreciate a "Black perspective" through which the client views the world. Instead, the clinician should be diligent in exploring and appreciating the particular cultural context of his/her client. This includes ethnicity, heritage, religious affiliations, and other factors such as club affiliations, neighborhood codes, family system protocols, etc. The cultural context and consequent world view of an adolescent Black Male

born in Costa Rica, immigrated to America at age three, raised in an intact home by parents struggling to assimilate, and rooted in a heritage wherein Caribbean influences are more prevalent and relevant than African ones is bound to be different from a Black female recently migrated to the North from the deep South with a Baptist heritage and family roots extending directly to the African tribe from which her ancestral slave was abducted. A great risk is run when a filter of "Black culture", "Black perspective"... is applied to the condition and experience of any Black individual: the risk of missing the individual hidden in the nebula of race categorization.

If the notion of "Black culture" can be dismissed with, and replaced with a clinical vigilance to discern the real ethnocultural context of the client and a sensitivity to the correlates of circumstance which impact Blacks in this society, then true cultural sensitivity in working with Black children becomes achievable. For it is as true for Black children as it is for any other people that

> Ethnic identification is an irreducible entity, central to how persons organize experience, to an understanding of the unique "cultural prism" they use in perception and evaluation of reality...Ethnicity also shapes how the client views his or her symptom..., determines the patient's attitudes about sharing troublesome emotional problems with therapists, attitudes towards his or her pain, expectations of the treatment and what the client perceives as the best method of addressing the presenting difficulties. (Parson, 1985)

What remains to be understood and appreciated in working with Black children are the existential aspects of their lives which may have bearing on the issue of sexual abuse. In our society there is an existential context common to Blacks that amounts to a shroud between each Black individual and the world she attempts to negotiate, a shroud wrapped as tightly and securely around the Black person as if it were skin. Pigmentation has not as yet been successfully separated from stigmatization in our society. Hence being identified and identifiable as Black brings with it meanings which along with and in spite of who one really is must be acknowledged and addressed by everyone on either side of the shroud of racism and its sequela of actual and psychological discriminations. While it is crucial, as has been stressed throughout this chapter, to acknowledge and appreciate the person beneath the shroud, it is unfortunately as important to understand how the individual in endeavoring to develop and maintain healthy internal structure is impacted by society's externally applied second skin. There are correlates of circumstance involved in being Black in this society which must be taken into account if thorough and effective clinical work is to be accomplished. The remainder of this chapter will discuss some of the most significant correlates of circumstance which impact sexual abuse in Black children.

In the three important areas of risk, reaction to, and availability for treatment of sexual trauma in Black children, there are several correlates of race which ought

to be taken into account. Research indicates that the majority of sexual abuse cases come from two-parent households. Non-two-parent household, however, are overrepresented, and, thus, at a higher risk than traditional two-parent families (about 4.4 times more vulnerable). (Tseng and Schwarzin, 1990) Household stress associated with family dysfunction and low income levels are also positively associated with increased risk for sexual abuse. (Tseng and Schwarzin, 1990) It is a commonly known fact that in our society Black children are overrepresented in both the categories of non-two-parent households and low-income households. It has further been found that White children have a higher incidence of molestation compared to Black children, who have higher incidence of rape, and that perpetrators are less often family relatives for Blacks than for Whites. (Tseng and Schwarzin, 1990, Pierce and Pierce 1984) In trying to discover and investigate the type of abuse which has occurred, assessing the probable family context in which it occurred, and looking for possible perpetrators then, the aforementioned correlates of the circumstances of Black children which impact risk are crucial.
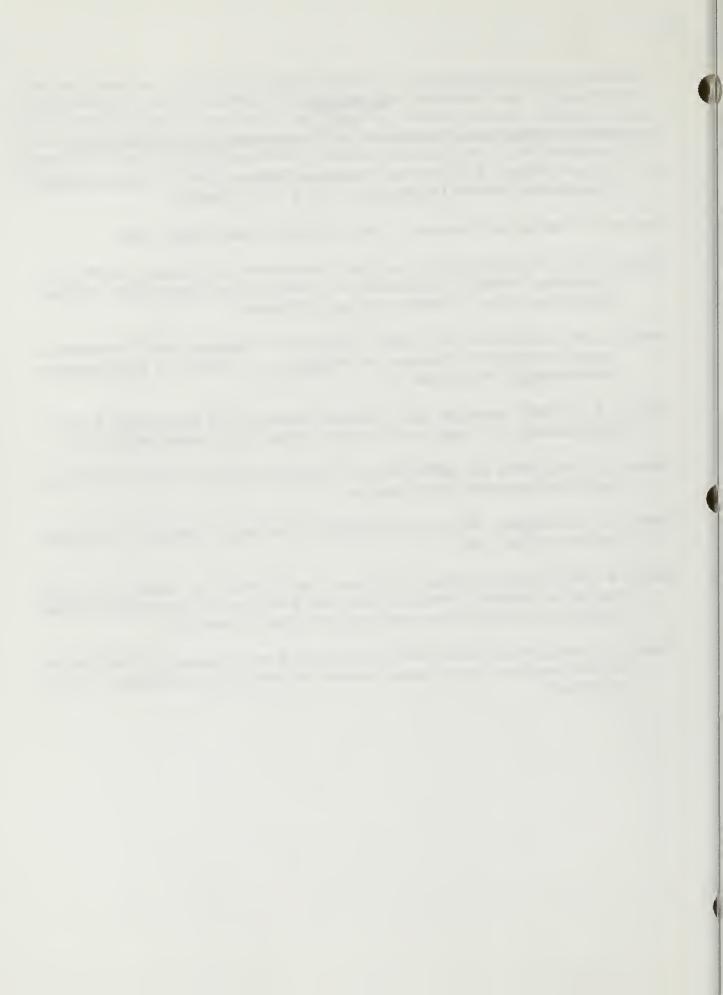
In addition to the above researched correlates of circumstance impacting risk, two other less quantifiable, and rather conjectural correlates which impact reaction to trauma and availability for treatment are worth considering. Regarding reaction to sexual trauma, the phenomenon of psychic numbing which occurs in victims of repeated and prolonged exposure to violence (directly and indirectly as witnesses) (Herman, 1992) should be factored into work with Black children. Inner-city children are predominantly Black, and inner-city children are increasingly exposed repeatedly and with regularity to scenes of violence, both as participants and witnesses. The possible effects of this include adaptation to, identification with, and numbing against such experiences (Bell and Jenkins, 1991). Given this correlate of Black circumstance, there is strong reason to be concerned that Black children who are sexually victimized, but who exist in an environment pervaded by violence, mistreatment, devaluation and neglect, may, tragically, not respond to sexual assault with the indignance, outrage and outcry that they should. Minimization, disavowal, not wanting to lose the precious little, if perverse, interaction she has with another person are all possible obstacles to a healthy reaction to abuse for the Black child.

Finally (but by no measure completing the range of correlates of circumstance of concern) regarding availability to treatment, at every phase, it must be acknowledged that the shroud, or second skin of all Blacks in this society is equally applied to Black children. One of the most detrimental effects of the shroud of racism is the alienation it establishes between people in need and people wanting to care for them. It must be acknowledged that there is often a wariness in Blacks of Whites, or non-Black individuals and institutions. The distance between the Black person inside the second skin, and everything and everyone on the other side can seem vast and can be arduous to bridge. For the Black child sitting across from a White investigator and being encouraged to tell her story, spill her guts, confide her pain... not only do the shame and horror attendant to sexual trauma have to be overcome; there also often must be a tremendous leap of risk and faith made in order to expose herself again to a person whose very physical presentation may

reflexively represent a threat. All of this in addition to the possible distances defined by ethnocultural context and individual idiosyncratic characteristics. A great deal of bridge building can be required. An empathic, sound clinical approach that appreciates a common human susceptibility to trauma, and recognizes trauma's incarnation in individual, ethnocultural, and existential context is the surest way to proceed.

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THE NEED FOR CROSS-CULTURAL STUDIES
OF ANXIETY DISORDERS

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Abstract:

This paper describes the need for research in the area of anxiety disorders among minority populations; specifically, along the dimensions of symptom patterns and somatization, co-morbidity, severity, onset and course, history of trauma, level of general functioning, relationship of demographic variables, help seeking patterns and effectiveness of treatment, and assessment strategies and methodology.

The Need for Cross-Cultural Studies of Anxiety Disorders

Judy Lam, M.A.

Goals and Objectives of This Paper:

This paper will attempt to describe the need for research in the area of anxiety disorders among minority populations in order to further promote cultural competence of service providers/programs. Most likely, an increased understanding of cultural strengths and differences of diverse populations will enhance the delivery of services in the treatment of this particular group of debilitating disorders.

Background and Significance:

To date, no comprehensive reviews of cross-cultural studies of anxiety disorders exist (Good and Kleinman, 1985). As a group of disorders which have been identified by recent studies to have a high prevalence in the general population, anxiety disorders have only been relegated to being a part of larger studies of cross-cultural psychopathology in general. Since cross-cultural studies specific to anxiety disorders among minority populations have not been conducted, the literature reveals little insight about the severity, course, level of functioning, effects of treatment, and assessment strategies specific to culturally diverse populations.

Although some of the literature suggests that the prevalence of certain anxiety disorders and complications associated with somatization, co-morbidity, history of trauma, and demographic variables are higher among some minority groups than for Whites, the majority of existing research studies have focused on the Caucasian population, have failed to consider racial, ethnic, and cultural factors as possible intervening variables, and/or have made assumptions about the universality of assessment strategies and methodology such as measurement tools and outcomes.

Efforts directed to address this under-representation of studies of minority populations in the area of anxiety disorders research are particularly important and needed in light of the high prevalence among some groups. Guarnaccia and Kirmayer (1992) express the belief that therapists and researchers are not active in this area because most are unclear about cultural differences. The differences in the way anxiety is described and experienced by minorities may lead to confusion and in turn avoidance on the part of most professionals. For example, researchers may find it difficult to operationalize the construct of anxiety using culturally competent criteria.

Symptom Patterns and Somatization:

In researching the prevalence of anxiety disorders among U.S. minority groups, the delivery of treatment services, and the effectiveness of intervention strategies, three critical questions emerge: 1) How does the prevalence of anxiety disorders differ among ethnic/racial minorities and the majority population? 2) Do the risk factors that contribute to the development of anxiety disorders differ among different minority groups? 3) And what are the differences in symptom patterns of expression of anxiety across cultures?

Goodwin, Guze and Robins (1969) found that the diagnosis of obsessional neurosis is a stable clinical entity across ethnic differences, however, the manifestations of OCD and other anxiety disorders differ among ethnic/racial groups and by gender. Khanna, Rajendra, and Channbasavanna (1986) reported that 412 people were diagnosed with obsessive-compulsive neurosis between 1975 and 1984 at the National Institute of Mental Health and Neurosciences in India. This rate is comparable to that found in studies of Caucasian samples. The characteristics abstracted by the authors from their sample were as follows: 1) a male to female ratio of 1:0.65,2) higher educational achievements, 3) average age of onset is 29.5 years, and 4) two distinct groups where one consists of single male patients (with earlier onset of disorder and treatment and duration of illness) and the other consists of married female patients (with onset about 10 years after marriage and earlier help-seeking efforts).

Paradis and his colleagues (1992) report that agoraphobia, simple and social phobias are more common among Blacks, particularly women, than in the White population. The prevalence rate for panic disorder is also higher among women (Friedman and Paradis, 1991). Bell and his colleagues (1988) found a higher frequency of Isolated Sleep Paralysis (ISP) among African-American subjects than Whites, perhaps because there is a greater vulnerability to stress that may serve as a predisposition to developing panic disorder. Bell and his colleagues (1988) concluded that Blacks may be more susceptible to panic disorder than Whites as demonstrated by the high numbers of persons with ISP who had not previously been diagnosed with panic disorder but who met criteria. ISP, hypertension and panic attacks are significantly related in Blacks. Because there appears to be a genetic predisposition to ISP that is complicated by environmental stress, Bell, Dixie-Bell, and Thompson (1986) that ISP may strike several members in Black families.

Fabrega, Mezzich and Ulrich (1988) found little difference in the prevalence of anxiety disorders between Blacks and Whites, but there were significant differences in the symptoms experienced by Blacks. For instance, measures of social aggression were significantly higher for Blacks than Whites. The presence of more social aggression may not reflect psychopathology so much as it may reflect the associated presence of social conflicts.

Differences in the prevalence of anxiety problems are also present in ethnic/minority children. Puerto Rican and Black children had a higher frequency of many problems including anxiety and fears than White children. Puerto Rican children in particular, suffer higher rates of sleep problems, anxiety, fear, and panic phobias (Canino et al, 1986).

Karno and colleagues (1987) found that Mexican-American men ages 18-39 have the highest rates of phobia and anxiety disorders for all men. The expression of symptomatology also differs for Hispanics. Ramos McKay and colleagues (1988) report that Hispanics, particularly women (Espin, 1987), will show high rates of somatic symptoms when suffering from emotional disorders. Further, research shows a link between mental health and health status of Hispanics. Wells, Golding and Burnam (1988) found that anxiety disorders were significantly related to perceived general health and actual physical functioning in Mexican-American subjects.

Whereas the link between somatic symptoms and depressive symptoms has been widely-accepted, Nayani (1989) reported a significant relationship between somatic symptoms and anxiety symptoms but not to depression when the Urdu version of the Hospital Anxiety Depression Scale was used in a sample of twenty Indians.

Some preliminary studies suggest that Southeast Asian refugees experience patterns of adjustment and psychiatric problems (e.g., depression and anxiety) similar to those documented in earlier studies of people who have suffered severe disruption and trauma in their lives (e.g., World War II refugees, prisoners of war, and concentration camp survivors). The symptom profiles of this group seem to be influenced by the multiple physical and psychological traumas (e.g., being shot at, chronic anxiety and stress, and rape) both before and during the escape (Kroll et al., 1989(. Kroll and his colleagues (1989) noted that the role of trauma and problems encountered during resettlement contribute to the physical and psychological problems associated with the acculturation of Southeast Asian refugees.

Some researchers posit that Asian American may be more anxious in social situations because of their socialization on "cultural values of modesty and self-effacement that inhibit the direct expression of personal wants (Zane, Sue, Hu, & Kwon, 1991, p. 63)." These authors added that Asian Americans may experience more anxiety and guilt across most situations when compared to Caucasians: "The results suggest that the cultural differences in assertiveness are not a matter of different social learning processes that underlie assertiveness. Rather ethnic differences in assertion are situational, with Asians reporting less assertive and feeling less self-efficacious than Caucasians, but only in situations involving strangers. Leung, Heinberg, Holt, Bruch (1991) examined the influence of parenting styles in the etiology of social anxiety across cultural backgrounds. The authors reported that the restrictive parenting style has a differential impact on the development of social anxiety in Chinese and Caucasian populations, and cautioned

that cultural conditions need to be taken into consideration in the interpretation of this style.

Clearly, there are differences in the prevalence and expression of anxiety symptoms among minorities although little research has focused on the causation and interplay of environmental stressors in the development of anxiety disorders. Guarnaccia and Kirmayer (1992) support the research on assessment of symptom patterns in minorities to enable more accurate diagnoses and more efficient treatment of anxiety disorders in
these populations.

Co-Morbidity:

Much less is known about the co-morbidity patterns with anxiety disorders among minorities than with Whites. Research shows that about 25% of cases of OCD will be accompanied by pronounced mood disturbances such as anxiety and depression (Goodwin, Guze, and Robins, 1969). This study does not account for racial differences in the prevalence of these secondary diagnoses. Alcohol and drug use/abuse are also problems associated with anxiety disorders. Robins and colleagues (1984) found drug and alcohol abuse/dependence are worse among urbanized Blacks that non-urbanized when examining the prevalence of anxiety problems in these groups. Clearly, the probability of co-morbidity problems having severe complications for the sufferers of anxiety disorders is high. However, little existing research addresses these problems among Blacks and even less among Hispanics and Asians.

Severity, Onset, and Course:

Little is known about the onset of anxiety disorders in general. However, Goodwin, Guze, and Robins (1969) reported that the onset of OCD across different ethnic populations was typically before the age of 25 (65%) with obsessions beginning in childhood or early adolescence. Only 15% will experience onset after the age of 30. Information on the severity and course of anxiety disorders among Hispanics and Blacks is not yet available and are an important part of any future study. Khanna and his colleagues (1986) reported that the mean age of onset of 29.5 years for population of Indians diagnosed with OCD.

History of Trauma:

The role of trauma in the development of anxiety disorders among minorities is particularly significant because the life circumstances of minorities, especially urbanized Blacks and Hispanics and Asian refugees, may encompass more severe stressors than in any populations. For instance, parental alcoholism seems to

play a significant and different role among groups. Hispanic Adult Children of Alcoholics were found to have higher rates of a variety of psychiatric problems including anxiety disorders than non-Hispanic Whites and Blacks (Harmon and Arbona, 1991). Parental loss and separation are also significant predictors of anxiety disorders. Friedman and Paradis (1991) found that African-Americans with Agoraphobia had suffered more parental loss in childhood and had been hospitalized more often than Whites.

Burnam and his colleagues (1988) found that sexual assault is predictive of several later psychological problems including anxiety disorders (panic, phobias, and OCD). These findings are generalized to all populations regardless of race. Neal and Turner (1991) and Perman (1966) that agoraphobia may be so high among African American women because they may be living in areas and circumstances so frightening, they may be unwilling/unable to leave their homes.

Kroll and his colleagues (1989) reported that 14% of a sample of 404 Southeast Asian refugees were diagnosed with Post-traumatic Stress Disorder with symptoms of pain and sleep disturbance. They also found that the experience of traumas either in the homeland during escape is positively correlated with symptoms of depression and anxiety.

Research has only begun to understand the obvious role trauma plays in the development of anxiety disorders across the life-span of minority persons. With the increase in urban violence and crime, it is critical to understand that exact relationship between the different types of trauma experienced by minorities and their effects.

Level of General Functioning:

The debilitating effect of anxiety disorders in the majority populations are more widely understood than the effects on minorities. However, the effects seem to be at least equally as devastating for minorities as for Whites. For example, anxiety disorders among Mexican Americans are significantly related to limitations in daily activities, job performance, and physical functioning (Wells, Golding and Burnam, 1988). At this stage, it is clear that the effects are detrimental, however, this is an area which requires further research to fully understand how the impact of anxiety disorders may effect minorities differently than Whites.

Relationship of Demographic Variables:

Several demographic variables that tend to differ for minority and majority populations are significant in the development of anxiety disorders. Marital status, education level, socio-economics, gender, age, and level of acculturation are all critical determinants in the prevalence of anxiety disorders.

Casas (1988) reported that anxiety related problems may be more pronounced in minorities, especially those of low socio-economic status (Casas, 1988). Blacks and Hispanics were among several minority groups for whom special societal stresses related to poverty and prejudice exacerbate anxiety problems. Paradis and colleagues (1922) found that, among Blacks, people who are separated or divorced, those with limited education, and persons of lower socio-economic status are more likely to develop anxiety problems. Canino et al (1986) found similar findings for Hispanics. Karno et al (1989) low socio-economic status is related to the high prevalence of anxiety disorders, especially agoraphobia, among Mexican Americans. Karno et al (1987) found age to be significantly related to anxiety disorders for Hispanics. Mexican American men 18-39 seem to show higher rates of OCD than those 40+. Phobic and panic disorders are more common in Mexican-American women 40 years or older.

The immigration status and level of acculturation of Hispanics and Asians is related to the development of a variety of emotional and mental health issues including anxiety disorders. Karno and colleagues (1987) states that U.S. born Mexican Americans experience more total anxiety disorders than Mexican-born Mexican Americans and non-Hispanics. Burnam and colleagues (1987a)) reported that phobias were more common among Mexican Americans with high levels of acculturation. They also found that Native Mexican Americans had more phobias than Mexican American immigrants probably because of the difference in length of time in adjusting to majority culture. Espin (1987) states that immigration status will particularly effect the mental status of Hispanic women.

Help Seeking Patterns and Effectiveness of Treatment:

Significant differences in treatment success, service utilization and drop-out rates between White and African American agoraphobia exist (Friedman and Paradis, 1991). Many racial/ethnic minorities have little or no experience with mental health services and may, therefore, seek assistance for psychiatric problems from medical professionals with unrealistic expectations (Casas, 1988). There is an underuse of mental health services for Blacks and Hispanics. Underutilization exists among minorities with anxiety disorders as well. For instance, of 102 diagnosed social phobics at the Center for Stress and Anxiety Disorders, only 4% of subjects were Hispanic or Black. The remaining subjects were all Caucasian (Heimburg, 1992). An on-going multi-site Harvard/Brown Study of anxiety disorders yielded less than 2% participation rate among minorities (Allsworth, 1992)

In addition to mistrust and lack of experience with the mental health system, minorities may be prohibited from accessing services because of child care costs and lack of insurance and transportation (Comas-Diaz, 1990). In addressing the low utilization rates among minorities, Constantino, Malgady and Rogler (1986) recommend an increase in bi-lingual and bi-cultural staff who can understand life

factors that prohibit treatment and who can offer culturally sensitive treatment. Zane, Sue, Hu, and Kwon (1991) reported that more and more Asian-Americans are seeking counseling services for increasing efficacy in interpersonal situations.

Addressing the effectiveness of treatment is equally as challenging. Few researchers have focused on treatment outcomes with Blacks and Hispanics for their anxiety disorders. Another factor important to attaining effective treatment is that of cultural sensitivity. Research efforts must approach these issues concurrently.

Little is known about the effectiveness of cognitive-behavioral treatment with minorities and the results of the existing research are not generalizable (Casas, 1088). Friedman and Paradis (1991) found that often misdiagnosis of panic disorder among inner-city Blacks leads to ineffectiveness in treatment because panic attacks are not recognized. Roughly 84% of White subjects were rated as moderately or significantly improved after treatment versus 33% of Blacks. Adebimpe (1981) states that the problems associated with differences in correctly diagnosing Black mental illness are related to stereotypes and culturally-insensitive treatment. Paradis and colleagues (1992) report that anxiety disorders are often under-diagnosed among Black patients. This is attributed to cultural differences in the description of symptoms and difficulties resulting between White therapists and Black clients.

A few therapeutic approaches seem to have shown either cultural sensitivity or neutrality in addressing anxiety problems with minority clients. Williams and Chambless (1992) found that there were essentially no outcome differences in the effectiveness of Exposure-Based treatment for African-American and Caucasian agoraphobics. However, the authors found that Black subjects tended to be more avoidant on self-report and behavioral testing and experienced more anxiety during behavioral testing. Behavioral (Stumphauzer and Davis, 1983) and Cognitive-Behavioral (Comas-Diaz, 1981) treatments have been found to be effective with Hispanics. Constantino, Malgady and Rogler (1986) found the use of Cuento (folktale) therapy adapted to Puerto Rican culture to be more effective in the treatment of those children with anxiety and behavior problems than non-adapted Cuento and traditional art therapies.

Lin, Poland, and Lesser (1986) cited findings from clinical studies which suggest a certain universality and responsivity of psychiatric symptoms to psychotropics which are not influenced by the patients' country of origin. However, dosage requirements seem to vary significantly across cultural backgrounds. One study found that Asians metabolize diazepam at a significantly slower rate when compared to Caucasians (Ghoneim, Korttila, Chiang et al., 1981). The treatment response to psychotropics in patients from minority populations is not clear because most studies use broad categories (i.e., Whites, Asians, Hispanics, and Blacks) and ignore the existence of many cultural subgroups within each of the four broadly defined groups.

Comas-Diaz (1990) points out the most important considerations in treating Hispanics is being aware of cultural implications such as immigration status and the level of acculturation. According to Burnam and colleagues (1987a)&b), level of acculturation is related to immigration status and may influence treatment outcomes. Espin (1987) explains that Hispanic women seldom approach therapy with complaints about difficulties in acculturation. Instead, the therapist must be aware that acculturation will effect, if not complicate, the existing problem. Espin (1987) and Baxter and colleagues (1981) emphasize that, even though an Hispanic client is bi-lingual, he/she learned to express emotion in their native language and not in their second. It is likely that the scope of emotion will not accurately be reflected in English. Humm-Delgado and Delgado (1963) note that the legal status of Hispanics will have an effect on needs assessment, and would, therefore, have an impact on treatment needs.

Comas-Diaz (1990) also show several other factors are important in treating Hispanics including the generational status of the client. Also, Hispanics tend to not differentiate between emotional and physical concerns and strong emotion can cause physical illness. Prevention and education should be integral components of service delivery. Because mental illness among Hispanics tends to be a family, not an individual affliction, treatment should incorporate the family.

Delgado and Humm-Delgado (1980) recommend the use of bilingual interviewers, cultural sensitivity in treatment, and service accessibility. Interagency collaboration may be one way to better coordinate and provide services to the Hispanic population. These recommendations apply to most Asian-speaking populations.

Less is known about the specific service needs of African Americans and Asian Americans. For these groups, the challenge is to provide outreach and effective services.

Assessment Strategies and Methodology:

Kroll and his colleagues (1989) discussed the complexity of diagnosing Asian populations: "The use of Western categories and concepts for organizing our comprehension of what individuals from the other side of the globe have experienced and are currently experiencing raises interesting issues (p. 1595)." The authors noted that Western cognitive structures and ethnocentric assumptions may not capture the essence of what ails people from other cultures, particularly when the diagnostic nosology (e.g., DSM-III-R) is based on Western concepts of psychological disability. Furthermore, the authors highlighted the difficulties associated with the assessment of the degree of severity of the impact of multiple stressors and traumas along the axis IV dimension of the DSM-III-R classification system. Often, most Southeast Asian refugees have experienced losses in six major areas of life (i.e., death, separation, job, material possessions, physical health, and

cherished ideas). In addition, most research studies of Asian populations required the services of an ethnic interpreter, although some worked in English with individuals who have acquired more proficient language skills.

A vital factor in the detection and treatment of anxiety disorders with minorities is the development of culturally-sensitive assessment instruments. Several instruments have been found to be valid in assessing anxiety disorders among minority populations. Because acculturation is such an important factor in any future study, a valid measure of this variable is necessary. The following measures have high validity and could be important assessment tools in any future study.

Good and Kleinman (1985) developed a model encompassing the factors that may differentiate the experience of anxiety disorders from one population to the next. Turner and colleagues (1989) developed the Social Phobia and Anxiety Inventory (SPAI) which incorporates responses from the cognitive, somatic, and behavioral dimensions of social fear. Vernon and Roberts (1982) chose the Schedule for Affective Disorders and Schizophrenic-Research Diagnostic Criteria (SADS-RDC) with Blacks, Hispanics and Whites to test rates of affective and non-affective disorders. There is also a SADS-L version which assesses current mental status.

The Diagnostic Interview Schedule (DIS) inquires about a variety of DSMIII-R diagnoses including the range of anxiety disorders. This measure is available in Spanish (Robins et al, 1981; Karno et al 1989; Burnam et al, 1987a&b, Friedman and Paradis, 1991). The Center for Epidemiologic Studies Depression Scale (CES-D) showed high detection of Generalized Anxiety Disorder (DIS) in Mexican-Americans but not Spanish-speaking Mexican-Americans. Paradis and colleagues (1992) found the ADIS-R effective in assessing panic and other anxiety disorders among inner-city Blacks.

Neal, Lilly and Zakis (1991) used the Revised Fear Survey Schedule for Children in their study that revealed that fears among children transcend race and culture. The Trait Anxiety Scale of the State-Trait Anxiety Inventory (available in Spanish) has been found to be an effective measure of anxiety in Puerto Rican children (Constantino, Malgady and Rogler, 1986).

Burnam and colleagues (1987) used the Acculturation Rating Scale for Mexican Americans to measure the level of acculturation among immigrant and native-born Mexican Americans. For a brief survey of clinical symptoms in a sample of Southeast Asian refugees who sought mental health treatment, Kroll and his colleagues (1989) developed an interview guide to obtain an estimate of symptom severity and overall psychiatric disability consisting of 19 symptom items (e.g., sleep, appetite, and memory disturbances) scored on a 4-point Likert-scale ranging from 0 = no or minimal symptoms to 3 = very severe symptoms. This interview checklist has not been validated against other measures but the authors stated that its use was justified because no standardized instruments are available for a culturally diverse

sample consisting of four Asian populations (i.e., Hmong, Laotian, Cambodian, and Vietnamese).

In assessing the PTSD syndrome, Kroll and his colleagues (1989) described conceptual issues as evidenced by the very ambiguity of the term "stress," which at times are defined as the external forces and at other times as the individual's internal reactions to "stressful" life circumstances. These authors' interview checklist included questions about what is the natural history of the response to overwhelming stress and trauma, and questions about diagnostic specificity and the relationship of PTSD to somatization, anxiety, and depressive symptoms (Kroll et al., 1989, p. 1596)."

Takeuchi, Kim, and Leaf (1989), in a factor-analysis of the responses of four ethnic groups (i.e., Caucasian, Filipinos, Japanese, and Native Hawaiians) to a standardized instrument (i.e., 54-item Symptom Checklist yielding five factors consisting of anxiety, depression, interpersonal sensitivity, obsessions-compulsions, and somatization), found that the minority populations appeared to have a poor fit between empirical and hypothesized factors when compared to Caucasians. Based on their results, the authors asserted that it is important for standardized instruments to be assessed for reliability and validity for use on minority populations. The authors reported that their findings are in line with these reported by other researchers of the symptom checklist (e.g., Hoffman & Overall, 1978; Holcomb et al., 1983; Derogatis et al., 1973; and Evenson, Holland, Mehta, & Yasin, 1980).

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PSYCHOTHERAPY APPROACHES WITH AFRICAN-AMERICANS: A HISTORICAL PERSPECTIVE

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Cross-Cultural Psychology: Past, Present, Future

Cross-cultural psychology refers to "the systematic study of behavior and experience as it occurs in different cultures, is influenced by culture, or results in changes in existing cultures" (Triandis, 1980, p.1). According to Atkinson, Morten and Sue (1993), a major purpose of cross-cultural psychology is to determine which psychological laws have universal application and which are culture specific. The terms etic and emic have been used to describe phenomenon that have, respectively, universal application or culture-specific application.

A veteran observer of psychology has argued that the field of psychology, in particular clinical psychology, is so rooted in the study of the individual that it lacks any appreciation of the social and cultural contexts in which people live (Sarason, 1974, 1981, 1985). In other words, psychology, especially clinical psychology, has tended to primarily focus its research on describing and understanding individual differences and how these individual differences influence behavior, cognitions, and affect rather than examining the effects of the complex interaction occurring between culture and other social forces (e.g., political economics, race, gender, class etc.) on behavioral mental processes (Rappaport, 1977).

The available data also suggests that mental health professionals have historically ignored or minimized the importance of cultural or ethnic differences that exist between themselves and persons of Asian, African, Native American, and Hispanic origins (Atkinson, Morten, Sue, 1979; Banks, 1977; Cheeks, 1976; Grier & Cobbs, 1968). Several authors have argued that because of this "benign neglect," clinical and counselor training programs have traditionally paid little, if any, attention to cross-cultural or ethnic variables that operate in the treatment context (Levine & Padilla, 1980; Marsella & Pedersen, 1981; Martinez, 1977; Pedersen, Lonner & Draguns, 1977; Thomas & Sullen, 1972; Vontress, 1969, 1971). Perhaps in response to these conditions, the Vail conference held in 1973 under the auspices of both the American Psychological Association (APA) and the National Institute of Mental

Health (NIMH) established a policy encouraging organized psychology to increase the number of minorities and to integrate racial and ethnic minority curricula into their graduate training programs. They suggested that it would be unethical to practice counseling or therapy with a person from a different culture without knowledge and training in cross-cultural issues potentially capable of affecting treatment outcome (Casas, 1987). For our purpose, culture is defined as the:

> totality of individuals' adaptation to the totality of the environment that they encounter... Culture consists of the totality of individuals' products... Some of these products are material, others are not... The fundamental purpose of culture is to provide the firm structures for human life that are lacking biologically... Biologically deprived of a human world, humans construct a human world... This world, of course, is culture (Berger, 1969).

At the institutional level, a number of organizations have developed over the past two decades to support research on the interaction between culture and other social forces (e.g., economic status, educational level) as issues related to cross-cultural counseling. Among these are the Institute on Pluralism and Group Identity of the American Jewish Committee, and the Spanish Speaking Mental Health Research Center at the University of California, Los Angeles (Lefley & Urrutia, 1982; Lefley, 1987). Research focusing on race as a factor related to effective cross-cultural counseling has benefitted from the infusion of ideas from anthropology, cultural psychiatry, and to some extent, counseling psychology.

Although there has been an increased awareness of the need for graduate faculty to integrate racial and ethnic minority curricula into their training programs, cross-cultural counseling or therapy training programs addressing culture, race, and ethnicity as clinical issues continue to be underrepresented, and as a result are variegated, experimental and relatively scarce." Three major programs are supported by the National Institute of Mental Health: Brandeis University's Training Program in Ethnicity and Mental Health (Spiegel & Papajohn, 1983); the University of Hawaii's Developing Interculturally Skilled Counselors (DISC) program (Pedersen, 1981a); and the University of Miami's Cross-Cultural Training Institute for Mental Health Professionals (Lefley & Urrutia, 1982). The University of Arizona has recently developed a new program as well (Akbar, 1990). According to Corvin and Wiggins (1989), models of cross-cultural training share the following characteristics:

1. A basic assumption that an individual's ethnic and cultural background significantly influences his or her worldview and the ways in which he or she experiences and understands life and its problems.

2. An emphasis on learning about various cultural groups (i.e., cultural worldviews) so that there is some understanding of

how an individual from a particular group may experience life and its problems.

3.   A focus on teaching counseling skills and interventions appropriate for use with members of various ethnic groups.

A recent survey of 106 clinical psychology programs was conducted to learn whether they taught minority related courses as a part of their training programs (Bernal & Padilla, 1982). Based on 76 returned questionnaires, the results indicated that only 16 programs taught minority-related courses focusing on the culturally different client. Presently, the American Psychological Association (APA) estimates that there are only 15 or 20 programs "that really have been proactive in developing training and [in] recruitment and retraining of minority students in psychology" (Guzman, 1990). In response to this situation, the APA Council of Representatives in August 1990 issued in its <u>Guidelines for Psychological Practice with Ethnic and Culturally Diverse Populations</u> an in-depth statement on the ethics and how-to's of working with a culturally diverse population (Moses, 1990).

A number of major issues have been suggested to explain the reluctance of psychology (in particular clinical psychology) to fully integrate cross-cultural issues into their graduate training programs: (1) Whether cross-cultural training should be an addition to the existing program or whether programs require a substantive change in structure; (2) curriculum concerns about theoretical and conceptual barriers (variability of faculty opinion regarding the importance of educating graduate students on minority issues); (3) institutional barriers related to economics and time (a general consensus exists among clinical psychology training directors that the training curriculum is already full: who will pay for this additional training?); (4) who is to be trained and at what level (undergraduate, masters, doctorate, post-doctoral, or continuing education programs); (5) what is to be taught (theory and research or applied courses); and finally, (6) can the usefulness of cross-cultural training be demonstrated empirically (Lefley, 1987)? However, according to Sarason (1974), the single most important explanation for clinical psychology's reluctance to incorporate the concept of culture into it's psychology graduate training programs is that to seriously investigate and gain insight into the nature and consequences of culture will have dramatic impact on the ways in which psychology views the individual. In other words, incorporation of the concept of culture would have serious implications for theory formation and clinical practice.

Notwithstanding this reluctance, <u>counselor</u> educators and <u>counseling</u> practitioners have acknowledged and encouraged the need for all counselors, whatever their cultural background, to work toward understanding the culturally different client (Arbuckle, 1972; Elliston, 1977; Van Buren, 1972). This trend is due, in part, to a growing recognition of the fact that a culturally "encapsulated" counselor is severely handicapped when it comes to meeting the mental health needs of an increasingly diverse racial and ethnic population in American society (Acosta, Yamamoto, & Evans, 1982; Marsella & Pedersen, 1981; McGoldrick, Pearce,

& Giordano, 1982; Pedersen, Draguns, Lonner & Trimble, 1981; Sue, 1981; Wrenn, 1962). For example, Wrenn (1985) has described how some cross-cultural clinical interactions "could threaten a majority counselor's equanimity." He also has examined types of cultural encapsulations and has recommended that majority counselors do the following to shore-up their lack of knowledge about various racial and ethnic groups: (1) take risks, step outside of yourself (your prejudices), become more aware and respectful of cultural differences; (2) begin to question what you have learned. That is, develop a healthy skepticism about the world and your role in it.

Thus, within psychology over the last two decades, publications focusing on issues relevant to cross-cultural counseling or psychotherapy have increased and have advocated changes in the mental health system by emphasizing the "match for fit" between therapist interventions and the cultural lifestyle or experiences of ethnic minority clients (Sue, 1990). Specifically, these researchers and practitioners have focused on: (1) the need for therapists to have some knowledge of other peoples' culture; and (2) the development of specific cultural techniques based on this knowledge (Pedersen, 1979, 1983; Sue, 1981, 1990).

Cross-Cultural Counseling and the Economically Disadvantaged

Cross-cultural counseling refers "to any counseling relationship in which two or more of the participants are culturally different" (Atkinson et al, 1993). Specifically, cross-cultural counseling has been described as "counseling in which the counselor and client perceive themselves to be culturally different - these differences having been acquired through socialization in distinct cultural, subcultural, racial, ethnic, or socioeconomic environments" (Ventress, 1971). A review of the research on cross-cultural counseling and psychotherapy indicates that, from the early 1940's until the late 1970's, psychotherapists were primarily concerned with the moderating effects of socioeconomic factors on treatment outcome with the economically disadvantaged (Baum & Felzer, 1964; Brill & Storrow, 1960; Garfield, 1978; Goin, Yamamoto, & Silverman, 1965; Gould, 1967; Hasse, 1964; Heitler, 1973, 1976; Jacobs, Charles, Jacobs, Weinstein & Mann, 1972; Jones, 1974; Karon & Vandenbos, 1977; Lee & Temerlin, 1970; Schaffer & Myers, 1954; Terestman, Miller & Weber, 1974; Warren & Rice, 1972). During the 1950's and early 1960's, psychotherapists were described as being highly reluctant to treat irrespective of race, ethnicity, or culture the socially "disadvantaged" (i.e., the working class and the poor) because they believed that they were "nonverbal" (Pinderhughes, 1973). Clinical lore has long held that the "disadvantaged" were inappropriate clients for therapy because they lacked the capacity for introspection - the ability to articulate ideas and feelings freely and exhibit the required amount of psychological mindedness (Jones & Matsumoto, 1982). The literature is replete with statements describing the "disadvantaged" client as holding different expectations about treatment and wanting action-oriented treatments that involve medication, direction, and advice (Overall & Aronson, 1963; Heitler, 1976). It has, until recently,

been commonly assumed that such clients achieve less successful outcomes in psychotherapy, even if they manage to successfully negotiate the obstacles of lack of availability of treatment, expense, and negative therapist attitudes that frequently bar their entry into treatment (Lorion, 1973, 1974, 1978). Despite the aforementioned attitudes, clinical practitioners during the 1950's and 1960's attempted to provide mental health services to the disadvantaged, which consisted of a significant number of racial and ethnic minority group members (Allen, 1970a; 1970b; Chess, Clark, & Thomas, 1953; Deane, 1961; Fishman & McCormack, 1969; Savits, 1952; Schneiderman, 1965). Thus, it appears that from the early 1940's through the late 1970's the success or failure of psychotherapy was a function of the therapist's attitude toward the disadvantaged. In fact, contemporary clinical lore suggests that the therapist, and not the patient or the technique, is probably the crucial target in efforts to improve treatment with the disadvantaged (Lorion, 1978).

Cross-Cultural Counseling and Race

Race has been a complex and controversial subject in American society and the social sciences, especially in psychology, since its inception (Gutherie, 1979; Jones, 1990; Thomas & Sillen, 1972). Throughout the relatively brief history of the United States, race as a construct has acquired different biological, political, economic, social, and psychological meanings. It has been used to define who shall enjoy the rights and privileges of citizenship, to what degree, and in what manner. Generally, in traditional psychology, race as a subject matter under empirical investigation has focused on individual or group differences between Blacks and Whites (Miller & Dreger, 1973). In essence, psychology, like the rest of American society, acted as if it was color-blind and was only interested in studying differences in behavior (i.e., attitudes, beliefs, cognitions, actions, etc.). This "blind spot" is the result of the socialization process within contemporary American culture (Kimmel, 1989). Kimmel states that "White people rarely think of themselves as 'raced' people, and therefore rarely think of race as a central element in their experience. But, people of color, on the other hand, are marginalized by race, and so the centrality of race is both painfully obvious and is in need of further study." For our purpose, a working definition of race is"

> A group of people who share biological features which come to signify group membership, and the social meaning such membership has in the society at large: it becomes the bases for expectations regarding social roles, performance levels, values for non-group members and in-group members alike... as a bio-social condition it is one of the most salient grounds for social categorization (Jones, 1990).

Simply put, within American society, an individual's race has significant social meaning because it tends to identify an individual as a member of a specific group and, as a result, it may affect the kinds of socio-political opportunities that the individual may or may not have access to because of group membership.

A review of the social-psychological literature provides some empirical support for the idea that an individual's perceived membership in a specific social category (e.g., race) has important social meaning and can result in negative or positive outcomes (Bogardus, 1928; Dovido, Evans, & Tyler 1986; Gibert, 1951; Jones, 1990; Karlins, Coffman & Walters, 1967; Katz & Braly, 1935; Katz & Hass, 1988; Katz, 1981). Within the psychotherapy arena, what has been the effect of therapists' perceptions of clients' race on the treatment process and outcome?

Review of the cross-cultural counseling and psychotherapy literature indicates that during the 1940's psychotherapists in the United States paid little attention to the role of racial differences in psychotherapy (Griffith, 1977). Sparse empirical research was conducted because of the waning interest of psychotherapists concerning racial variables in counseling or psychotherapy from the late 1940's through the 1960's (Dreger and Miller, 1960, 1968; Rosen, 1967). Prior to the 1970's, Kardiner and Ovesey (1951) and Grier and Cobbs (1968) were widely cited as the most scholarly efforts concerning race as a significant mediating variable in the psychological treatment of Black Americans. Both works focused on the psychological development of Black Americans under conditions of racial oppression. They were interested in the kind of adaptive strategies used by Black Americans to cope with racial oppression.

The effects of race on counseling and psychotherapy with Black Americans had become the focus of a number of clinical studies by the early 1970's. Some of the issues studied included transference and countertransference problems (Jones & Seagull, 1977; Schacter & Butts, 1968), therapeutic interactions between Blacks and Whites (Block, 1968; Gardner, 1971; Jackson, 1973; Jones & Seagull, 1977; Minrath, 1985; Sue, 1981; Waite, 1968; Wesson, 1975), the impact of social class (Acosta, Yamamoto, & Evans, 1982; Brill & Storrow, 1969; Carkhuff & Pierce, 1967; Jones, 1974; Mayo, 1974; Sue 1981; Yamamoto & Goin, 1965), problems related to racial bias in the delivery of mental health services (Acosta et al., 1982; Anderson, Bass, Mumford, & Wyatt, 1977; Cole & Pilisuk, 1976; Gibbs, 1975; Jackson, Berkowitz, & Farley, 1974; Sue, 1977; Warren, Jackson, Nugaris, & Farley, 1973), and the use of traditional clinical techniques with Black patients (Banks, 1975; Cheeks, 1976; Harper & Stone, 1974; Shipp, 1983; Sue, 1981; Tounsel & Jones, 1980; Wilson & Calhoun, 1974; Wyatt, Strayer, & Lobitz, 1976). Recently, the findings of a study conducted by the Institute for Southern Studies suggested that "race not only determines who gets committed to institutional psychiatric care and where they get sent, but also influences how patients are treated" (Salmon, 1989). The study concluded that there are racially discriminating practices in the mental health system.

Four major reviews of this literature have appeared over the last 10 years. The first major review of published and unpublished literature focused on race (Black and White) as a counselor-client variable in counseling and psychotherapy (Harrison, 1975). The second major review focused on therapist-client similarity between races as a salient variable affecting counseling and psychotherapy, and

examined literature from the fields of counseling, psychotherapy, and social work (Sattler, 1977). The third major review focused on Black-White pairs in counseling, psychotherapy, and social work (Abramowitz & Murray, 1983). The fourth major review includes studies focusing on counseling with Native Americans, Asian Americans, Hispanics, and Blacks (Atkinson, 1983).

A meta-analysis of these earlier reviews on cross-cultural counseling and psychotherapy indicate three important features: (1) a primary focus on Black and White clients as therapeutic pairs; (2) a predominant use of survey or archival research design; (3) sources of clinical samples (mental health clinics serving clients on an outpatient basis, and psychiatric hospitals serving clients on an inpatient basis). More recently, college counseling center clients and undergraduate psychology students seeking help have been used as samples for many cross-cultural counseling studies (Atkinson, 1985).

Clinical researchers (Abramowitz & Murray, 1983; Atkinson, 1983; Harrison, 1975; Sattler, 1977) organize their analyses of cross-cultural research data in this area around seven categories of dependent variables: (a) client use of mental health services; (b) client preference for a counselor of a specific race; (c) counselor preference for a client of a specific race; (d) effects of counselor prejudice on the counseling process;(e) differential diagnosis of clients' problems based on racial factors; (f) differences in the counseling process as a function of racial similarity; (g) differential treatment of clients as a function of racial factors. A comparative analysis of these earlier reviews suggests that researchers did not categorize dependent variables in a consistent manner. That is, researchers did not operationally define the dependent variable(s) consistently across the studies examined. As a result, review outcomes may be a function of organizational (research design) strategy as well as objective analysis (Atkinson, 1985). To date, analogue and survey studies examining how race as a variable influences treatment have produced discrepant findings, such that the effects of client and therapist race remain an open question (Abramowitz & Murray, 1983; Atkinson, 1985; Griffith & Jones, 1978; Parloff, Waskow, & Wolfe, 1978; Sattler, 1977). However, it should be noted that this finding should be considered with caution because most of the studies examined only between-group differences and ignored within-group differences. This is important because "such within-group differences as racial self-identification, racial identity development, social class background, and cultural commitment affect preference for counselor race or ethnicity" (Atkinson, 1983). More importantly, the limited research on racial matching clearly suggests that treatment effects are likely to be reflected more in the process than in the outcome of psychotherapy (Jones, 1978).

Cross-Cultural Counseling and Ethnicity

The increasing ethnic diversity of the American society is apparent from population statistics. There has been a sizeable growth in the population of ethnic

minority groups from 1970-1980, and an even larger proportion of ethnic minority groups is projected by the year 2000 A.D. for example, if we consider projections from the year 1980 to the year 2000, the Asian population is projected to grow by 97%; Blacks by 24%; Hispanics by 71%. In contrast, the White population of about 180,000,000 million is expected to have a growth rate of about 11% (Sue, 1990). Demographers predict that early in the 21st century, approximately one-third of the United States population will be members of an ethnic minority group (Jones, 1990).

Review of the cross-cultural counseling and psychotherapy literature suggests that the concepts of race and ethnicity are used interchangeably to describe characteristics and experiences of different cultural groups in American society, and, as a result, have contributed to confusion in the literature (Johnson, 1990). This "categorical double-talk" has significant implications for clinical research and practice with clients from different cultural groups, given this country's greater recognition of the projected demographic changes and the increasingly culturally and ethnically plural nature of American society.

The term ethnicity has many divergent meanings. Ethnicity, as a concept, has been defined as "belonging to, or distinctive of, a particular racial, cultural, or language division of mankind (Funk & Wagnalls, 1972). For our purpose, ethnicity is defined as a "social psychological sense of peoplehood in which members of a group share unique social and cultural heritage that is transmitted from one generation to another" (Sue, 1990). In other words, we argue that ethnicity is an individual's self-perception, identity, attitude, or belief that is related to one's bio-social (i.e., racial) definition. In addition, culture and ethnicity give meaning to skin color (Jones, 1990).

The formation of an ethnic identity addresses important social and psychological needs of individual group members. The function or purpose of the development of an ethnic identity for individual group members is suggested to be the following:

> Ethnic identity provides an individual with a sense of historical continuity to life, a continuity based on preconscious recognition of traditionally held patterns of thinking, feeling, and behaving that is the cornerstone of a sense of belonging (Arce, 1982, pp. 137-138).

According to Johnson (1983), the difference between culture and ethnicity is one of degree and circumstance rather than kind. It has been suggested that ethnicity as a dimension of a group can occur as follows:

> Only under certain social and psychological conditions is ethnicity in any meaningful sense aroused, or one might say constructed... the ethnic self-identity constructed by members of a particular generation of a social group will be a function of the cultural contacts of that group

with other groups; different circumstances will generate different "ethnicities" (Mercer, Mercer, & Mears, 1979, p. 16).

In agreement with the observations of Mercer, et al. (1979), ethnic groups have been described as follows:

A collection of persons who occupy an ethnic platform, recognize and value their common occupancy - share an identity - and are organized and therefore have a common interest in maintaining their association (Jackson, 1984, p. 208).

In the interest of science, further clarification of the concept of ethnicity is provided by Moore (1974) when he stated:

Great races do have different cultures. Ethnic groups within races differ in cultural content. But people of the same racial origin and the same ethnic groups differ, in their cultural matrices. All browns, or Blacks [sic], or whites, or yellows, or reds are not alike in the cultures in which they live (pg. 41).

In essence, it appears that various ethnic groups within racial categories have their own unique cultures (Johnson, 1990). Ethnic identity has been conceptualized as a complex and multidimensional construct that is the template for such factors as ethnic identity formation, ethnic identification, language, self-esteem, degree of ethnic consciousness, and ethnic unconsciousness (Devereux, 1980).

In the last twenty years, a growing number of articles have been published examining the role of ethnicity in the counseling process (Atkinson, Morton, & Sue, 1979; Bernal, Knight, Organista, Garza, & Maez, 1987; Bulhan, 1980; Cross; 1971; Garcia, 1982; Keefe & Padilla, 1987; Phinney & Rotheram, 1987; Rodriquez & DeBlassie, 1983; Ruiz, 1990). Review of studies in the cross-cultural counseling and psychotherapy literature suggest that only one study has examined Mexican-American minority clients' preference for ethnically similar therapists, in particular as it affects their attitudes toward counseling or psychotherapy (Sanchez & Atkinson, 1983).

Another population that has received only limited attention in this line of research is African-Americans. Continual and thorough study of ethnic identity and its relationship to the counseling or psychotherapy process is needed, given the historical neglect of the topic, its importance in the formulation and application of a comprehensive counseling or psychotherapy approach, and its ever-increasing relevancy in working with ethnically different clients (Casas, 1987; Casas, Ponterotto, & Gutierrez, 1989; Jackson & Kirschner, 1973). Thus, the paucity of research related to the function and interaction of ethnic identification (i.e., ethnic orientation or cultural identity) among African Americans as related to the treatment process and outcome, is a glaring omission in the counseling and psychotherapy literature.

Cross-Cultural Counseling, Knowledge, and Techniques

Review of the cross-cultural counseling and psychotherapy literature suggests that mental health professionals who have attempted to use traditional clinical intervention strategies with African-American clients have met with limited success (Banjks, 1975; Branch, 1977; Griffith, 1977; Jackson, 1973; Jones, Gray, & Jospitre, 1982; Vontress, 1971). Lorion (1978) stated:

In general, assessment of the mental heath delivery system's ability and willingness to respond to the socioemotional needs of the low-income and minority segments of society have been negative and pessimistic... racial and socioeconomic parameters are seen as insurmountable barriers to providing effective psychotherapeutic intervention (p. 903).

The President's Commission on Mental Health (1978) also pointed to a number of problems encountered by ethnic minorities in the service delivery system:

Racial and ethnic... continue to be underserved... It makes little sense to speak about American society as pluralistic and culturally diverse, or to urge the development of mental health services that respect and respond to that diversity unless we focus attention on the special status of the groups which account for the diversity... Too often, services which are available are not in accord with their cultural and linguistic traditions... A frequent and vigorous complaint of minority people who need care is that they often feel abused, intimidated, and harassed by non-minority personnel. Like everyone else, minorities feel more comfortable and secure when care is provided by practitioners who come from similar backgrounds (pp. 4-6).

More importantly, reviews of drop-out research indicate negative treatment outcomes - client alienation and early termination (Baum, Felzer, D'zmura, & Shumaker, 1964; Brill & Storrow, 1960; lief, lief, Warren, & Heath, 1961; Overall & Aronson, 1963).

Data from the Seattle Project also indicate that over 50% of African-Americans, Native Americans, and Asian-Americans fail to return to therapy after one session; the rate is 42% for Chicanos. Each group's rate is significantly different, generally $p < .001$, from the 30% rate for European American (White) clients (Sue, 1977).

Some reasons that contemporary researchers and practitioners have posited to explain the poor treatment outcome with ethnic minority group members include: (1) the therapist's inability to provide culturally responsible forms of

treatment, presumably due to (a) unfamiliarity with the cultural backgrounds and lifestyles of various ethnic-minority groups and (b) therapists (Black and White) having had training, which is developed for Anglo, or mainstream Americans; (2) the lack of bilingual therapists; (3) stereotypes therapists have regarding ethnic minority clients; (4) racism and discrimination; and that (5) ethnic minority groups frequently find mental health services strange, foreign, and unhelpful (Akbar, 1977, 1981; Azibo, 1990; Baldwin, 1984; 1989; Grier & Cobbs, 1968; Flower, 1971; Friedman, 1966; Heitler, 1976; Hunt, 1960; Riessman, Cohen & Pearl, 1964; Sue, McKinney, Allen, & Hall, 1974; Sue, 1977; Sue & Sue, 1977; Thomas & Sullen, 1972; Vontress, 1971, 1988; Windham, 1976; Wolkon et al., 1973; Yamamoto & Goins, 1965; Yamamoto, James, & Palley, 1968).

Because of the unresponsiveness of the mental health system to the needs of ethnic minorities, in particular African-Americans, some researchers and practitioners have focused their research on understanding the role of cultural knowledge in facilitating positive treatment outcomes. They emphasized that "treatment should 'match or fit' the life-style or cultural experiences of the clients" (Sue, 1987, p. 38). They believed that this process of matching or fitting was especially important when the therapists and the clients were members of different cultural, racial, ethnic, or class backgrounds (S. Sue, 1977; Snowden, 1982).

Several African-American psychologists have come to believe that understanding the psychological impact of culture, specifically the African culture, is central to addressing the problems of African-Americans (Akbar, 1976, 1977, 198a; Azibo, 1989; Baldwin, 1980b, 1985; Dodson, 1981; Gutman, 1976; McAdoo, 1982; Nobles, 1978; Stack, 1974; Sudarkasa, 1981). Specifically, a number of African-American psychologists concerned with the prevention and treatment of mental health disturbances displayed by African-Americans have adopted or incorporated into their clinical posture an "African-American" perspective. This perspective refers to the science of mind and behavior that is rooted in the traditional African worldview (Akbar, 1976, 1977, 1981; Azibo, 1982, 1982a, 1983a, 1983b, 1983c, 1989, 1990; Baldwin, 1981 1992; Frye, 1980; Khatib & Nobles, 1978; Meyers, 1981a, 1981b, 1984, 1988; Nobles, 1972, 1974; Phillips, 1990; X Clark, McGee, Nobles, & Weems, 1975; White, 1984; White & Parham, 1990).

The traditional African worldview or cosmology is a conceptual system that assumes that "reality is both spiritual and material at once, everything becomes one thing, spirit manifesting" (Myers, 1988). It also posits that the nature of the human phenomenal universe is 'social' i.e., humans live and exist in a social universe from which derives all meaning and significance for the individual" (Baldwin, 1981). The basic ontological position of the Africentric worldview, reflecting the culture, philosophy, and history of Africans and African (Black) Americans, is captured in the phrase "I am because we are" (Mbiti, 1970; Nobles, 1980). In essence, this phrase describes the social psychological collective reality of Africans and African (Black) Americans.

Recently, an "Africentric" (i.e., African cultural centered) theory of African (Black) personality has been developed as a conceptual framework for understanding and describing traits, beliefs, and attitudes displayed by African-Americans that are assumed to have had their origin in traditional African philosophy and culture (Akbar, 1976, 1979; Baldwin, 1976, 1980, 1980b, 1981, 1984, 1985, 1987, 1992). That is, an Africentric conceptual framework has been developed to interpret African-Americans' psychological functioning and behavior from the perspective of a value system (a set of norms, ritual practices, and social organization) based on the distinct history, culture, and philosophy of African people (Baldwin, 1984). Central to this Africentric paradigm is the assumption that the behavior of African-Americans are not due solely to the net effects of racism and cultural oppression, rather, such behaviors also reflect the expression of traditional African cultural-based affirmative forces interacting with those of racial oppression (Baldwin, 1979, 1984, 1985, 1992).

The Africentric theory of the African (Black) personality suggests that the structure of the African (Black) personality consists of several culturally-specific psychological and behavioral traits. A major core component of the African (Black) personality has been identified and is called African self-consciousness (Baldwin, 1981, 1984, 1992). The African self-consciousness is posited to be similar to a cardinal trait (Allport, 1937, 1961, 1966). It is, to a large extent, a dynamic trait that compels the manner in which a person organizes his or her life.

Factor analysis of the African self-consciousness construct based on the African Self Consciousness (ASC) scale (Baldwin et al., 1985) has identified the following trait structures, attitudes, and behaviors:

a. The person possesses an awareness of his/her Black (African) identity (i.e., a sense of collective consciousness) and African cultural heritage, and sees value in the pursuit of knowledge of self (i.e., African history and culture throughout the world - encompassing the African American experience).

b. The person recognizes Black survival priorities and the necessity for institutions (practices, customs, values, etc.) which affirm Black life.

c. The person actively participates in the survival psychosocial liberation, and proactive development of Black people and defends their dignity, worth, and integrity (Baldwin & Bell, 1985).

Baldwin's Africentric personality theory (1981) also attempts to address issues related to consistency of behavior across situations, i.e., behavioral-situational specificity (Mischel, 1968). Thus, the display of attitudes and/or behavior by Blacks that is not in accord with the principles embodied within the African Self-

Consciousness disposition is explained in terms of "variations in the personal and institutional support systems characterizing the developmental and experiential life space of the individual" (Baldwin & Bell, 1985). Baldwin argues that both individual difference and collective behavior among African-Americans can be explained using this Africentric framework. In other words, within-group differences between African-Americans evidenced by their attitude or behavior can be explained to some degree by their commitment or lack of commitment to their culture (Baldwin, 1981, 1987; Baldwin & Bell, 1985)

Consistent with Baldwin's model, Akbar (1979, 1981) has proposed a classification system of mental disorders among African-Americans. According to Akbar (1979, 1981), under conditions of cultural, economic, social, political and racial oppression, many African-Americans experience great stress resulting in three kinds of culture-specific maladaptive response patterns, i.e., mental disorders: (1) Alien-self disorders (characterized by a denial or rejection of one's own cultural values in attempting to assimilate into the majority White-American culture); (2) Anti-self disorders (characterized by a tendency to over-identify with the anti-Black hostility in the dominant White-American culture; and the (3) Self-destructive disorders (characterized by acts of self-destruction that result from the faulty attempts of the person to cope with frustrations associated with the many impediments to growth and development, as well as to feelings of security and well-being under racially oppressive social conditions). Collectively, these three culture-specific maladaptive response patterns describe the existence of severe distortion in African-American's African Self-Consciousness, that is, African-Americans who are not committed to their culture.

African-Americans who evidence distortions in their African Self-Consciousness orientation are also described as being "psychologically misoriented" (Baldwin, 1980a, 1980b). Psychological misorientation refers to "an incorrect orientation to reality that appears functionally normal within the framework of Euro-American culture because of social cues and institutional support systems" that reward Black Americans who psychologically assimilate into mainstream culture rather than making a commitment to their culture of origin (Baldwin, 1980a, 1980b). "Psychological Misorientation," therefore, refers to the condition of the absence of an African-American cultural orientation in Black Americans being inaccurately regarded as culturally appropriate, and thus a functionally normal orientation (Baldwin, 1984).

On the other hand, there is a positive side to psychological adaptation for those African-Americans who do not become psychologically misoriented, and as a result, succumb to the above maladaptive patterns. In short, it has been suggested that those African Americans who make a commitment to their culture as expressed by their level of African-Self-Consciousness orientation tend to be more psychologically healthy within the context of African-American culture (Baldwin, 1984). In other words, they engage in a variety of Africentric behaviors and activities: obtain membership in predominantly African-American organizations and groups,

attend African-American cultural events, read books about African-American/African culture, etc. Several theoreticians have highlighted the healthy psychological aspects associated with some African-American cultural traits reflecting the strength of African-American people. For example, Nobles (1974, 1978, 1980) has emphasized the concept of strong group identification of "we-ness" orientation, affective responsivity, flexible concern with time, and a basic spiritual orientation as positive Black American cultural traits. Similarly, Akbar (1979), Luther X (1974), and White (1980) have focused on the growth-promoting aspects of African-American culture and consciousness.

Notwithstanding the above theory and observations, at this time no consensus among scholars has been reached regarding the etiology of many of the psychological disturbances occurring among African-Americans (Welsing, 1979). Existing explanations are mostly theoretical and somewhat speculative. Few empirical studies presently exist, but this situation is beginning to change (Jones, 1990, 1991). Some African-American professionals have begun to develop research programs to address the issues of the role of African-American cultural factors in behavior and mental health outcomes (Baldwin, 1980, 1980b, 1989, 1992; Jones, 1990; Langley, 1990, 1992; Parham, 1989; Parham et al., 1981; Phillips, 1990; Williams, 1981; White, 1980, 1984; White & Parham, 1990).

Notwithstanding these advances in knowledge concerning the relationship between the African-Americans' culture, mental health, and the development of culture-specific treatments, the field of psychology continues to be perplexed by the problems of how to increase the effectiveness of mental health services to African-Americans (Sue et al., 1987; Sue, 1990). This observation is important given the fact that some literature suggests that "stress for the African-American is perhaps more varied, more intense, and more sustained than almost any other cultural group" (Hillard, 1985).

Again, it is important to remember that at the institutional (system) level, training therapists to be sensitive to their ethnic minority clients' cultural background has proved to be very difficult because of: (1) reluctance by faculty to change the recruitment and admission policies, resulting in a continued underrepresentation of ethnic minority students in graduate psychology programs; (2) significant underrepresentation of ethnic minority faculty in graduate psychology programs; (3) curricular concerns, i.e., lack of willingness by faculty to change curricula to more adequately reflect issues relevant to minority concerns; (4) training issues, i.e., a limited number of faculty interested and knowledgeable about mental health issues affecting ethnic minority clients (Atkinson & Wampold, 1981; Bernal, 1980; Barnel & Padilla, 1982; Kennedy & Wagner, 1979; Moses, 1990; Parham & Moreland, 1981; Tipton, 1984).

Because of the above difficulties encountered in achieving a "match or fit" between the therapist and the client, an alternative and controversial strategy was suggested and implemented by some mental health professionals: the development

of <u>culture-specific</u> treatment or intervention techniques based on the knowledge of the culture of the specific client.

According to Sue (1977, p. 39), the mental health system encountered problems related to the process of matching or fitting and as a result "rather than simply advocating the necessity for therapists to be culturally sensitive and to know the cultural background of clients, some investigators began to specify culturally specific intervention strategies to use with ethnic clients." For example, several clinical researchers suggested that Asian Americans tend to prefer counselors who provide structure, guidance, and direction rather than non-directedness in interaction (Atkinson, Maruyama, & Matsui, 1978).

On the other hand, clinical researchers believe that African-Americans tend to prefer a more action-oriented and externally focused (as opposed to an intrapsychic) approach (Calia, 1966). In other words, most of the culture-specific treatment interventions designed for use with African-Americans appeared in toto to be methodologically similar to behavior therapy, with an emphasis on the role of cultural factors as determinants of behavior (Allen, 1978; Calia, 1966; Jackson, 1980; Jackson, A., 1983; Jackson, J., 1976; Jones, 1978; Jones, 1987; Majors & Billson, 1992; Myers, 1985; Snowden 1982; Sue, S., 1988; Smith, 1982; Sue, 1987; White, 1984; White & Parham, 1990).

Although each of the proposed culture-specific treatment models tend to emphasize different aspects of the African-American experience, they all reflect the same basic assumption: it is important to serve an adaptive function in the African-American culture into the treatment process.

Clinical researchers are now beginning to acknowledge the influence of culture, ethnicity and gender as salient mediating variables affecting positive treatment outcomes with ethnic minority groups, perhaps for two reasons: (1) recognition that the ethnic-minority population has grown to represent 17% of the nations' total population and (2) enlightened self-interest (Sue, 1990).

Cross-Cultural Counseling, Credibility and Gift-Giving

Recently, a reformulation of the role of culture and culture-specific techniques in psychotherapy designed to address the mental health needs of ethnic minorities has been posited. It suggests that knowledge and sensitivity to the ethnic minority clients' culture and the use of culture-specific techniques is necessary, but not sufficient (Sue & Zane, 1987). That is, the authors acknowledge and emphasize that the lack of knowledge of ethnic minority clients' culture is detrimental. However, they believe that even with this knowledge, "its application (by means of culture-specific treatment strategies), and relevance cannot always be assumed, because of individual differences among members of a particular ethnic group" (Sue et al., 1987, p. 39). In essence, they view current cross-cultural approaches (cultural

knowledge and/or the use of culture-specific techniques) as <u>distal</u> from the goal of positive treatment outcome. Specifically, they argue that:

> the major problem with approaches emphasizing either cultural knowledge or culture-specific techniques is that neither is linked to particular processes that result in effective psychotherapy... therapists' knowledge of the culture of clients is quite distal to therapeutic outcomes in the sense that the knowledge must be transformed into concrete operations and (intervention) strategies (p. 29).

Therefore, they recommend that future research addressing the problem of providing mental health services to ethnic minority clients should <u>not</u> focus solely on such distal factors as cultural knowledge or the use of culture-specific techniques, but, instead should aim at <u>understanding the nature and quality of the therapeutic relationship</u>, i.e., whether the ethnic minority client perceives the therapist as "credible and giving" (Sue et al., 1987, pp. 40-42).

More importantly, they suggest that the study of the processes underlying the clients' perception of therapists as credible and giving provide more specific targets for clinical intervention because: (1) they can help therapists be more effective, especially in serving ethnic minority clients; (2) they cut across different theoretical and treatment approaches (psychodynamic, client-centered, behavior therapy, etc.) even though they are not all that is needed for positive treatment outcome; (3) they enable therapists to break up the processes related to therapeutic effectiveness into components and provide more specific goals for treatment, training, and research, and (4) each ethnic minority client's individual uniqueness can be taken into consideration. They argue also that credibility and giving are related to notions of expectancy, trust, faith, and effectiveness. That is, they hypothesize that credibility and gift-giving facilitate positive treatment outcomes in treatment.

Credibility is defined as "the client's perception of the therapist as an effective and trustworthy helper (Sue et al., 1987, p. 40). The role of therapist credibility in treatment is critical. Outcomes of treatment are better when clients believe in their therapists and in the methods being employed (Frank, 1959; Phares, 1984). The authors add that credibility must be achieved in the first one or two sessions.

Two factors that enhance the credibility of the therapist are: (1) <u>Ascribed status</u>, which refers to the position or role that one is assigned by others as a result of, for example, age, social status, and sex. For instance, in traditional African culture, the youth is subordinate to the elder, the woman to the man, the naive person to the authority, and so on (Staples, 1989); (2) <u>Achieved status</u>, which refers more directly to the skills and actions of the therapist such as culturally consistent interventions, accurate empathic understanding, and the ability to accurately assess and help clients. The focus on the credibility factor allows for analysis of potential problems such as underutilization of services and premature termination of treatment displayed by ethnic minority groups. The lack of <u>ascribed</u> credibility may

account for the underutilization of services by ethnic minority groups. On the other hand, the lack of <u>achieved</u> credibility might better explain premature termination (Table 1).

<u>Table 1</u>

<u>Factors in Credibility</u>

Ascribed Credibility	Achieved Credibility	
	Low	High
Low	Client avoids treatment; if already in treatment, premature termination likely	Client avoids treatment; if already in treatment expectations exceeded and may stay in treatment
High	Client likely to enter treatment; high expectations are not realized so may terminate prematurely	Client likely to enter treatment; high expectations are realized by skills of therapist

Table 1. From Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. <u>American Psychologist,</u> <u>42,</u> p. 41.

Sue et al. (1987) hypothesize that <u>achieved</u> credibility can be examined in terms of three areas in which cultural issues are important:

(1) <u>Culturally consistent conceptualization of the problem</u>--the credibility of the therapist is diminished if the client's problems are conceptualized in a manner that is not consistent with the client's belief systems (i.e., worldview);

(2) <u>Culturally responsive means for problem solution</u>--the therapist's credibility will be diminished if the therapist requires the client to respond in ways that are not culturally acceptable or uncomfortable;

(3) <u>Congruity in goals for treatment</u>--if discrepancy between goals or criteria for assessing the effects of therapy by the client and that by the therapist arise, credibility of the therapist will be diminished.

Simply, the authors hypothesize that underlying the ethnic minority client's perception of the credibility of the therapist are the exchange of culture based values (i.e., worldviews, belief systems, traditions, etc.) that may influence client-therapist conceptualization of the problem, means for problem resolution and the setting of mutually agreed-upon goals to alleviate the presenting problems.

Further, if there are discrepancies in problem conceptualization, means for problem resolution, and the setting of mutually agreed upon goals to mitigate the client's presenting problems between the client and therapist (as a result of differences in cultural values, beliefs, or attitudes), then it is hypothesized that the ethnic minority client's perception of therapist credibility is significantly reduced and, as a result, leads to negative treatment outcomes (Sue, et. al., 1987).

In contrast, 'giving or gift-giving' refers to "the client's perception that something was received from the therapeutic encounter" (Sue et al., 1987, p. 41). That is, ethnic minority clients must perceive, or feel that they are receiving, some direct benefit (gift) from the treatment. The process of giving can be conceptualized as a forum for building rapport and a trusting relationship. According to Sue et al. (1987), benefits or meaningful gains must be given and perceived early in therapy to prevent premature termination. Examples of gifts include alleviation of emotional discomfort, normalization (the realization that their thoughts, feelings or experiences are commonly encountered by others as well), anxiety reduction, repression relief, cognitive clarity, reassurance, hope, faith, skills acquisition, providing a coping perspective, and goal-setting. This author also posits that if the ethnic minority client perceives that the therapist truly understands the nature of his/her presenting problem within the context of his/her cultural values, then that behavior would also constitute a "gift." Finally, with regard to the psychotherapy process, they argue that therapists working with ethnic minority clients should "minimize problems in credibility while maximizing gift-giving" (Sue et al., 1987, p, 44).

In summary, Sue and Zane's (1987) reformulation of the role of culture and cultural techniques in psychotherapy attempts to address a major limitation in previous cross-cultural research by emphasizing that the two processes of credibility and gift-giving should be the focal point of psychotherapy research and therapy.

More importantly, the authors suggest that whether the ethnic minority client perceives the therapist as credible is determined by the <u>exchange of cultural values</u> between the client and the therapist, and by the behavior of the <u>therapist "giving" some gift</u> (i.e., identifying, understanding and addressing the presenting problem(s) of ethnic minority clients within the context of their culture).

Relative to the parameters of credibility and gift-giving discussed by Sue et al. (1987), results of a recent study suggest that cultural similarity between client and therapist may not be as important as the therapist's perceived cultural sensitivity and trustworthiness (LaFromboise & Dixon, 1981).

With specific regard to African-Americans, review of the cross-cultural literature indicates that "relative to Whites, Blacks are less trusting" (Terrell & Barrett, 1979; Terrell & Terrell, 1981; Watkins Jr. & Terrell, 1988; Watkins Jr., Terrell M., & Terrell, 1989). With regard to the behavior of African-Americans in a counseling or therapy context, it has been argued that "African-American clients tend to 'size up' therapists and tend to be wary of them" i.e., distrust them (Jenkins, 1985).

A plausible reason for African-Americans' distrust of European-American (White) therapists is that, in the "majority of clinical situations, Blacks are evaluated as if they were exclusively a variant of European-American culture, without acknowledgment of, and respect for, their African-American cultural experience, values, and belief systems (Jackson, 1983). In other words, African-Americans accurately perceive that therapists generally are not trained to be culturally sensitive, and as a result, mistrust them.

With respect to African-Americans' trust of African-American therapists trained in traditional graduate psychology programs, a African-American psychologist has suggested that:

> Eurocentric-oriented training has virtually rendered us (Blacks) incapable of providing any type of culturally relevant services to Black people. Thus, we often end up treating Black people as if they were 'White people in Black skin,' with only their experience of European racism being viewed as their distinguishing psychological characteristic (Baldwin, 1989, p. 70).

In other words, African-Americans trained in traditional graduate programs in psychology are equally as likely as European-Americans to be culturally insensitive to African-American clients who seek their help.

The psychotherapy literature, which focuses on process variables, suggests that regardless of one's theoretical orientation, a "good therapeutic relationship between the therapist and patient is an important requirement for progress" (Garfield, 1989, p. 25). Rogers' (1951, 1954, 1957) well-known approach to

psychotherapy has specified that trust, unconditional positive regard, congruence, genuineness, and expression of accurate empathy must be present, but are not sufficient conditions by themselves if therapy is to be effective. What is most important is that the client is able to perceive that the therapist accurately understands and appreciates his or her subjective view of reality. That is, Rogers' (1951, 1954, 1957, 1958) advice to therapists was to listen to what people said about themselves, to attend to their concepts and to the significance they attach to their experiences, and then communicate the understanding gained through the process of <u>accurate</u> empathy back to the client (Rogers, 1947, 1951, 1957, 1959).

Accurate empathy is theoretically described as the "ability of the therapist accurately and sensitively to understand the client's experiences and feelings, and their meaning to the client during the moment-to-moment encounter" (Rogers & Truax, 1967).

More recently, the definition of accurate empathy has been expanded to include the therapist's ability to accurately and sensitively understand the <u>cultural</u> origins of a client's experience and feelings and their meaning to the client during the moment-to-moment encounter. For example, describing the nature of the helping relationship, Sarason (1985) states:

> Any conception of the helping process that is not based on a conception
> of the nature of our complex society and how it intrudes directly and
> inevitably into the clinical-client interaction automatically restricts the
> achievement of that process's therapeutic objectives (p. 147).

In other words, the therapist who draws upon her or his knowledge of the ethnic minority client's culture, and then uses his or her knowledge of the ethnic minority client's culture to aid the process of problem conceptualization, problem resolution, and setting of mutually agreeable treatment goals can be perceived by ethnic minority clients as accurately understanding the nature of their problems. The ability of the therapist to communicate to minority clients (African-Americans, in particular) an accurate understanding of their problem within the context of their culture and subjective reality would represent an act of "giving," and as a result, may increase the probability of the therapist being perceived by the ethnic minority client as being credible. Simply speaking, accurate empathy (the therapist's ability to communicate cultural knowledge, sensitivity and respect) can be perceived by ethnic minority clients, especially African-Americans, as a direct benefit of treatment, i.e., a gift.

In summary, other than the inconsistent data about preference for <u>racially</u> similar therapists (Abramowitz & Murray, 1983; Atkinson, 1983, 1985; Harrison, 1985; Sattler, 1977), little empirical information is available in the cross-cultural counseling or psychotherapy literature about the effects of <u>cultural/racial/identity</u> as a within group variable affecting African-Americans' attitudes toward counseling or psychotherapy (Parham & Helms, 1981, 1985a, 1985b). Likewise, there is a paucity of

data on the effects of a African-American client's <u>commitment to her or his cultural values</u> on counseling-related issues, such as, the client's perception of therapist as credible.

Cross-Cultural Counseling, Cultural/Racial Identity, and Credibility

In America, people of African descent have gone from being colored, nigra, negro, Negro, black, Black, Afro-American to the now-preferred African-American. The question of identity, in particular, racial-ethnic identity has over the past two decades held the interest of many scholars (Akbar, 1979, 1989, Azibo, 1989; Baldwin, 1979, 1981, 1984, Baldwin & Bell, 1985; Baldwin, Duncan, & Bell, 1987; Baldwin & Hopkins, 1990; Baldwin, Brown, & Rackely, 1990; Bell, Bouie, & Baldwin, 1990; Cheatham, Tomlinson, & Ward, 1990; Cross, 1971; Elion & Megargee, 1979; Erikson, 1968; Fannon, 1967; Hardiman, 1979; Helms, 1990; Hilliard, 1972; Jackson, 1975, 1976; Majors & Billson, 1991; Nobles, 1989; Parham & Helms, 1975; Thomas, 1970; Williams, 1981; Woldemikael, 1989).

Identity development models have been developed for Asian-Americans (Sue, 1981; Latino people; Keefe & Padilla, 1987) and for European-American or White people (Gaertner, 1976; Hardimann, 1979; Helms, 1985, 1986, 1990). Beginning in 1970, African-American psychologists developed several models of Nigrescence (the process of becoming Black) (Cross, 1971; Jackson, 1976; Kirk; 1975). With respect to African-Americans, the Cross model of Black identity development has become the most cited and researched in the racial-ethnic identity literature (Helms, 1985, 1986, Parham, 1989; Parham & Helms, 1981, 1985a, 1985b; Pomales et al., 1986; Ponterotta et al., 1986).

According to Akbar (1989), "the concept of Nigrescence (or converting to Blackness) has engendered considerable conceptual discussion within the ranks of social scientists specifically concerned with the effective psychological functioning of Black people in America." The Nigrescence models, however, do have some limitations. Essentially, they are transformational as opposed to formational models of identity development. In particular, they "explain the process or processes of moving psychologically from non-Blackness to Blackness, and converting persons with low levels of Black pride to high levels of Black consciousness <u>in response</u> to certain common and noxious stimuli: <u>racism</u> and <u>oppression</u>" (Williams 1981). To put it another way, the Nigrescence models describe the transformation and development of Black consciousness primarily in response or reaction to some negative social condition. According to Myers et al. (1991), "few of these identity models have been systematically developed, and even fewer have been empirically validated using the logical positivist tradition upon with they were based."

Recently, Janet Helms, Thomas Parham and others have conducted empirical studies focusing on the effects of <u>within-group differences</u> on counseling process and outcome. In particular, these researchers and others have begun to include

African-Americans' attitudes toward racial identity and other measures of within-group differences as independent variables in studies of counseling process and outcome (Helms, 1985, 1986, Parham & Helms, 1981, 1985a 1985b; Pomales et al., 1986; Ponterotto et al., 1986). Although these authors have examined within-group differences, they relied upon a conceptual framework that describes Black behavior as <u>reaction</u> to environmental presses. In particular, the theoretical position of the authors posits that Black identity development occurs in response to some kind of negative situation or environment. Essentially, the authors theoretical position is a reactive rather than affirmative position (Akbar, 1989).

According to Akbar (1989), the "implication of a transient Nigrescence is inconsistent with the theoretical writings of Akbar (1979, 1981), Baldwin (1981, 1984), Nobles (1976), and others who have argued that Black/African identity is a biogenetically determined core of the Black self." As has been stated, this paradigm assumes that African-American psychological functioning and behavior are culturally based, deriving from and reflecting the distinct African-American social reality of worldview (Baldwin, 1987; Nobles, 1972).

Recently, a number of African-American psychologists have posited a radically different view of the <u>formation and development</u> of African/Black consciousness (Akbar, 1979, 1981; Baldwin, 1981, 1984; Nobels, 1980). According to Akbar (1989) and others:

> African/Black identity is a <u>biogenetically</u> determined core of the Black self. When one is out of touch with this self (i.e., Pre-encounter) one is in a pathological, misoriented, or disordered state. The African/Black self emerges as a <u>natural</u> expression of one's human development within the natural supportive environment of one's <u>culture</u> (p. 2590.

The theoretical approach adopted by the above social scientists have come to be called the Africentric approach to Black personality (Akbar, 1984; Azibo, 1983; Baldwin, 1981, 1987; Nobles, 1972; Williams 1981). The "Africentric" conceptual framework is one which interprets African-American (Black) psychological functioning and behavior from the perspective of a <u>value</u> system (a set of norms, rituals and practices, and social organizations) based on the distinct history, culture and philosophy of African people which prioritized the affirmation of African-American (Black) life, its cultural integrity and authenticity (King, Dixon & Nobles, 1976; Nobles, 1972, 1986). In other words, within this framework, concepts of the African-American (Black) experience as a function of their being members of an authentic cultural system (Baldwin, 1981, 1984; Nobles, 1980, 1989; White, 1984, Williams 1981).

The development of the African Self-Consciousness Scale (ASC Scale) provided social scientists with a psychological instrument that was culturally-specific to the African-American (Black) experience. In particular, scholars had a tool that would allow them the opportunity to empirically examine and measure

<u>cultural</u> factors presumed to contribute to the formation and development of the African-American (Black) personality i.e., the African/Black identity (Baldwin & Bell, 1985).

Over the past five years, several empirical studies have been conducted for the purpose of examining the relationship between African self-consciousness and background factors (parental attitudes and values, early childhood experiences), environmental factors (racial social setting), involvement in culturally-specific activities (participation in pro-Black behaviors and cultural events), and personality traits (personal causation) Baldwin, Brown & Rackley, 1990; Baldwin, Duncan, & Bell, 1987; Bell, Bouie, & Baldwin, 1990; Gibson, 1984).

Recently, an empirical study has examined how cultural/racial identity and cultural commitment as within-group variables effect African-American male college students' perceptions of therapist credibility (Langley, 1992). Findings indicated that a significant number of African-American male college students who scored high on cultural/racial identity and cultural commitment thought that it was important that a counselor or therapist have an <u>approach to counseling or therapy that takes into consideration the client's cultural background and experiences.</u> This result suggests that African-American male students in this study tended to value an approach to counseling or therapy that is culturally sensitive, and also supports the theory that it is important that counselors or therapists appreciate, understand, and use their knowledge of the ethnic minority client's culture to establish rapport and <u>achieve</u> credibility (Sue et al., 1987).

In addition, results of this study indicated that a significant number of students who scored high on cultural/racial identity and cultural commitment thought that it was important for a therapist <u>to prescribe a method of treatment (clinical intervention) that is consistent with the cultural background of the client</u>. This result suggests that students believed strongly that the means that a counselor or therapist selects to address the African-American client's presenting problem (means of problem resolution) should not violate the norms of the client's culture. That is, as much as possible, a counselor's or therapist's clinical interventions should be consistent with the African-American's or other minority client's cultural background and experiences.

The above findings support the theory of a number of ethnic minority cross-cultural researchers who have hypothesized that cultural knowledge and sensitivity, culture-specific clinical interventions and the development of a therapeutic (working) relationship designed to address ethnic minority clients' presenting problems within their cultural frame of reference will likely increase the chances of the therapist being perceived as credible (Sue et al., 1987; Sue, 1990).

According to Atkinson et al (1993) an examination of the "cross-cultural research published in the 1980s indicated that although racial identity development and acculturation, as factors effecting minorities were being studied, there appeared

to be a need for theory based research relevant to the cultural experiences of ethnic minority populations." The Langley (1992) study was an attempt to address this deficit in the cross-cultural counseling literature by investigating whether the Africentric theory of Black personality formation and development could be useful in understanding the behavior of African-American (Black) males in a clinical context i.e., in counseling or psychotherapy.

Recommendations for Future Research

A review of the cross-cultural counseling and psychotherapy literature related to counseling African-Americans indicates that most of the empirical studies over the last twenty years have focused on the effects of class or racial differences on the process and outcome of counseling or psychotherapy (Abramowitz & Murray, 1983; Harrison, 1975; Sattler, 1977; Atkinson, 1983, 1985).

Future research focusing on identity formation and development in African-Americans should attempt to confirm or disconfirm the assumptions inherent in the Africentric paradigm. Assessment of African self-consciousness would seem essential to a substantive and thorough assessment and understanding of Black mental health.

In addition, given the predicted demographic shift in America, future research should continue to examine the effects of cultural, racial, and ethnic similarity between the counselor and client. Nothing in the research to date suggests that all African-Americans view all European-American counselors as inappropriate sources of help (Atkinson, 1987), As E. Jones (1985) stated so cogently:
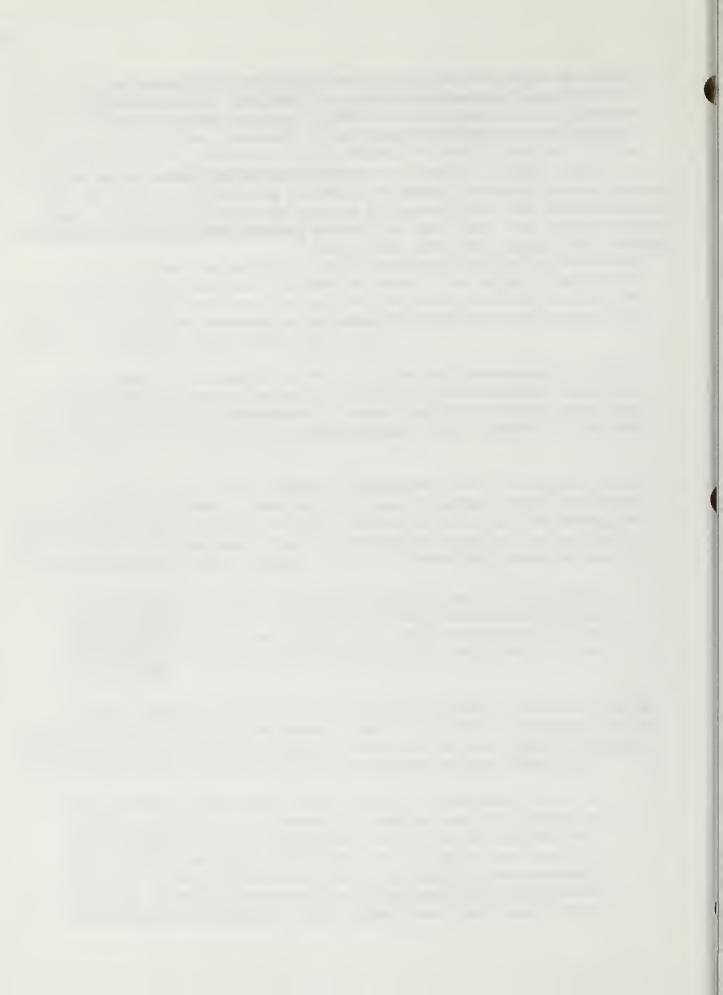
> It is the therapist's quality of self-understanding, as much as cultural understanding, that is important in treating the Black client; and although culture and race clearly play a role, they should not be emphasized in a way that obscures the unique individuality of the person (p. 178).

Finally, clinical, counseling, and school psychology graduate training programs should conduct an evaluation of their curriculums to determine whether up-to-date information is given to students related to providing culturally sensitive mental health services to ethnic minorities. According to Harry Tomes (1992):

> Throughout the next century there is likely to be increased social and political pressure to increase the number and availability of psychologists who comprehend the behavior of people across the racial and cultural spectrums...Psychology, as a science, has enormous potential to make contributions in an increasingly diverse society. However, to do so it will need to expand the knowledge base of psychology by developing a research agenda with a multi-centric focus.

Such an agenda--incorporating the acquisition of behaviors in a multicultural, epistemological context-- would lead to understanding of all human grouping, and make important contributions to education, work, and health (p. 41).

In other words, he argues that organized psychology cannot afford to do business as usual. However, if faculty in psychology graduate programs choose to do so, he states that this would mean that graduate and professional schools would function with no eye to the future and produce psychologists of limited social and scientific utility (Lorion, 1973, 1978; Tomes, 1992).

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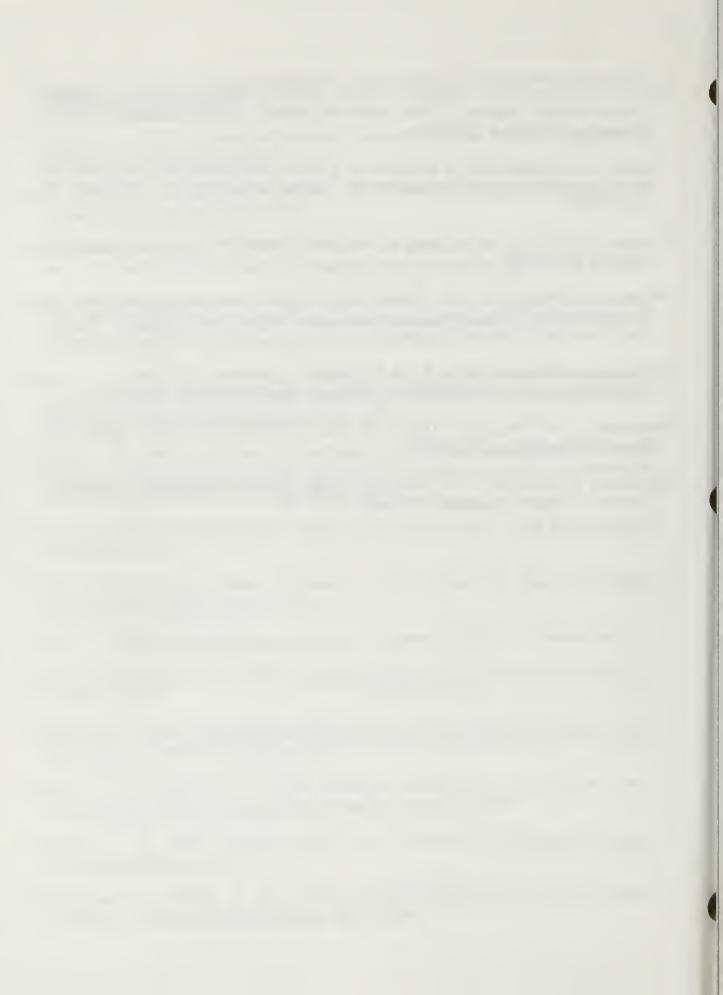Rosen, A. (1967). Client preferences: An overview of the literature. Personnel and Guidance Journal, 46, 785-789.

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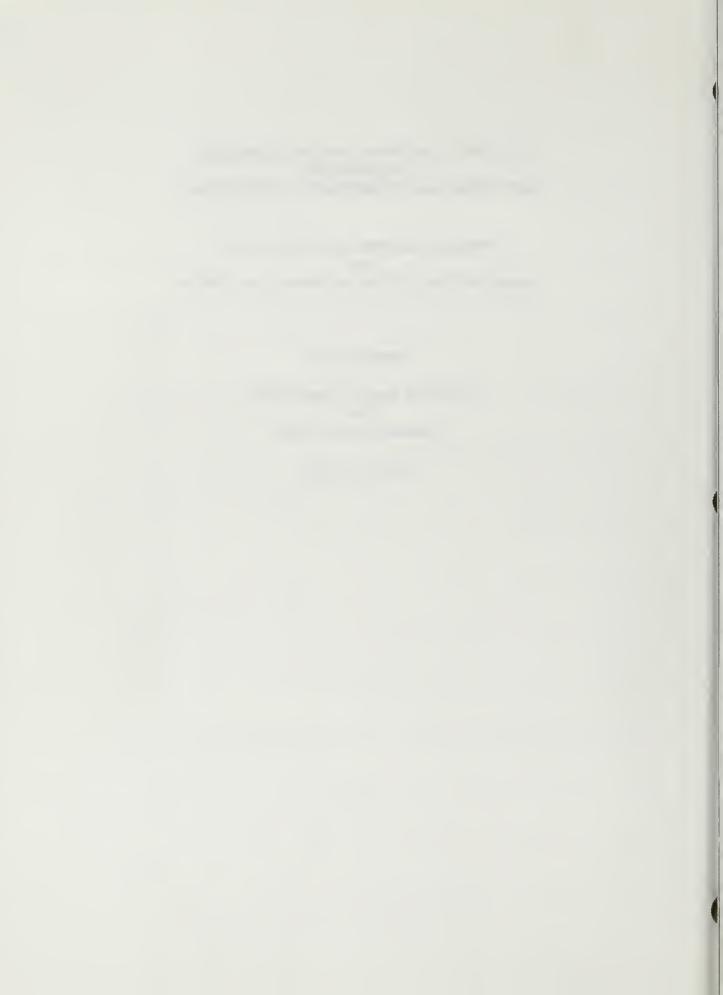
SERVING CHILDREN AND ADOLESCENTS
OF COLOR IN
INPATIENT AND RESIDENTIAL PROGRAMS

"Removing Barriers to Effective Care"
by
Angelo McClain, LICSW & Bhavini Joshi, MSW

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REMOVING BARRIERS TO EFFECTIVE CARE

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This presentation focuses on issues that child/adolescent inpatient and residential programs must address in delivering mental health services to children and adolescents of color. The presentation looks at how child/adolescent programs help clients build self esteem and develop coping skills for dealing with the pressures of daily living. The presentation also examines the crucial role that the Department of Mental Health (the responsible State agency) plays in challenging, supporting, encouraging, and providing leadership to programs as they remove the barriers which negatively effect care provided to children and adolescents of color.

According to 1990 census reports, White Americans represent 80.3% of the total US population as compared to 83.1% of the population in 1980. Black Americans represents 12.1% of the total U.S. population as compared to 11.7% in 1980. Hispanic Americans represent 9% of the total US population as compared to 6.4% in 1980. Asians represent 2.9% of the population as compared to 1.5% in 1980. Native Americans represent 0.8% of the population as compared to 0.6% in 1980. According to 1990 Massachusetts census report, 89.9% of the population is White, 5.0% is Black, 2.4% Asian, and 4.8% Hispanic.

The Massachusetts Department of Mental Health (DMH) reported 136 admissions of children under age 14 to Gaebler Children's Center, the State's only public psychiatric hospital for children. From 2/90 to 11/91; 33% of those admissions were Black, Hispanic, or Asian children. During the same time period, there were 662 total admissions of children under age 14 to public, private, or general hospitals. Of those admissions, 28% were Black, Hispanic or Asian children. According to October 1992 DMH client registry data, 69% of clients served by DMH were White, 13.7% Black, 6.9% Hispanic, 0.8% Southeast Asian, 0.6% other Asian, 0.1% Pacific Islander, 0.1% Native American/Alaskan, 2.1% Cape Verdean, and the remainder either other or unknown. 47% of clients ages 0-5 were White, 59% of clients ages 6-11 were white, 68% of clients ages 12-15 were White, and 73% of clients ages 15-18 were White. These numbers clearly demonstrate that our society and concomitantly the clients we serve are becoming more culturally diverse.

Department of Mental Health child/adolescent programs recognize that in order to provide effective mental health treatment services to children and adolescents of color, they MUST remove barriers which have traditionally affected these consumers' and their families ability to fully utilize and benefit from treatment services. Providers remove barriers by delivering treatment services which emphasize: recognition of these consumers' treatment needs; helping clients form a positive self identity; building self esteem; maintaining and respecting language; understanding and coping with racism; celebrating and preserving cultural heritage and customs; and teaching self empowerment.

Department of Mental Health child/adolescent program managers realize the important role that they play in assisting programs in removing barriers to effective care. Program managers support, encourage, and challenge programs to use creative approaches; offer suggestions for ways to remove barriers; and advocate for culturally competent services.

This presentation examines seven barriers which have traditionally prevented children and adolescents of color from fully utilizing and benefitting from treatment services offered at mental health treatment programs. Barriers are identified and how the barrier negatively impacts on treatment is discussed. A "barrier buster" for each barrier is identified, and examples of how programs utilize these barrier busters is presented.

The barriers are denial, negative self-identity, low self-esteem, inability to communicate, racism, denial of heritage and customs, and disempowerment. The barrier busters are recognition and acknowledgement, positive self identity, building self-esteem, respecting language, understanding racism, maintaining heritage, and teaching self empowerment.

Barrier Denial

Traditionally, many mental health inpatient and residential treatment programs have denied that children of color had special treatment needs which required adaptation of the standard treatment modalities which were not designed to address the needs of children and adolescents of color. Programs have either denied or minimized the specialized treatment needs of these consumers, which has resulted in the failure to adapt programs to meet the specific needs of children of color.

Breaking through denial is the first and primary barrier that must be addressed. Denial often takes the form of emphasizing cultural similarities rather than acknowledging cultural difference. Everyone is modulated by the culture in which s/he has been educated in which s/he lives. The culture of a society is the collection of ideas and habits which are learned, shared and transmitted from one generation to another (Linton 1956). Black et al. (1991) suggest that treators should acknowledge the differences and resist the temptation to assume the client's experience is similar to their own. Denial also takes the form of failure to identify children of color's, preferences and likes. In order to be effective, multi-cultural mental health services must include an appreciation of individual differences along with the recognition of the characteristics shared in common (Lloyd, 1987).

Barrier Buster: Recognition & Acknowledgement

Recognizing and acknowledging the need for culturally sensitive treatment for these consumers is the barrier buster which is used to break through denial.

Programs have been involved in sensitivity training, diversity training, consciouness raising discussions, discussions with professionals of color, discussions with families of color, and actively listening to children and adolescents of color to identify and recognize the needs and interests of consumers of color and to recognize their own biases. In order for treatment to be effective, providers must become aware of their own values and biases and separate them from those of the client (Holiman & Lauver, 1987)

DMH child/adolescent programs have conducted in-service training, sent staff to training conferences, and requested consults from professionals of color in an effort to increase the program's recognition and acknowledgement of the need for culturally sensitive treatment for children of color. For example, providers acknowledge that contrasts between Anglo and Hispanic cultures create a sociocultural distance between treator and client that requires bridging in the form of culturally sensitive treatment. Constantino et al. (1988) discusses the factors of the migration, acculturation, language, and socioeconomic barriers confronted by Hispanics have been linked to higher prevalence rates of mental disorder, anxiety and depression, drug and alcohol abuse, delinquency, and lower self-esteem compared to ethnic populations such as Blacks and Whites. Providers must understand such factors when developing culturally sensitive treatments.

Rogler et al. (1987) uncovered three distinct approaches to the delivery of culturally sensitive mental health services. The first approach involves increasing the accessibility of services to the Hispanic consumer through: a) embedding programs within the Hispanic community; b) to employ bilingual and bicultural staff; c) to create programs or intervention teams specifically for Hispanics; d) to provide interpreters; e) to insure that services are provided in an atmosphere that does not alienate the client. The second approach involves selection of treatments which coincide with the perceived cultural characteristics of the client. For example, Maduro and Martinez (1974) suggest that Jungian dream analysis is suitable for Mexican Americans, since folkhealers in Mexican culture often rely on the interpretation of dreams in providing folk healing remedies. The third approach involves bringing Hispanic cultural characteristics into therapeutic play within a standard modality. Kreisman (1975) successfully treated Mexican Americans who thought themselves to be bewitched. Constantion et al. (1986) conducted a study using cuentos or folktales as a story-telling technique to promote adaptive personality development in Puerto Rican children. The folktales were selected to foster cultural values, pride in ethnic heritage, and adaptive coping behaviors. The children readily identify with the Puerto Rican characters in the folktales, and by role-playing the stories, children's adaptive behaviors are reinforced by the therapist. The stories about the heroes and heroines not only contain biological information, but also highlights of the adversities faced by the characters and how they were able to cope and overcome the adversities. Providing therapy for Hispanic youths requires the professional to become aware of both the cultural implications of the interaction and the personal biases that impact on treatment gains (Black, et al., 1991). A person's culture determines whether an experience is seen as inherently

stressful (Doku, 1990). Similarly, methods of coping with symptoms and the outcome of an illness are affected by one's culture. As programs increase their recognition and acknowledgment of the needs of children of color, there should be a corresponding increase in their understanding of the importance of breaking through the barriers which negatively impact on these consumers' ability to benefit from treatment services.

Another way programs have increased their recognition of the needs of children of color is by listening to their former and current clients of color. Draguns (1981) found that it was especially helpful to the counseling relationship to use the experience. Listening has helped understanding and understanding provides the necessary impetus to make appropriate program changes. It is critical for current consumers to believe that they can discuss the experience of the placement and believe that their needs will be taken into consideration as the program adjusts to meet the needs of its client population. Some former patients talk about how they felt a lack of understanding of who they were and that many of their needs went unmet.

Another way to increase acknowledgement is for programs to conduct multi-cultural assessments with their staff with followup discussions. Discussions should be open and frank enough to allow people to discuss their fears, concerns, prejudices, and allow for staff to openly discuss their feelings of inadequacy in meeting the needs and long term treatment needs of consumers of color. Black et al. (1991) concluded in their study of providing counseling services to Hispanic males that:

> "...the helping professional should become acquainted with the attitudes and behaviors likely to be encountered while working with the troubled Hispanic male adolescent: possibly stereotyped in sex roles; more likely to adopt parents' and siblings' ideologies; more cooperative and dependent in social and cognitive styles; predisposed to anxiety-related problems from marginality; less mature in moral choices; lacking in specific role taking experiences at higher levels of moral development; lower in academic self-concept, possibly with negative attitudes toward own ethnic group; impulsive and reticent to allow the open expression of suppressed anger; high in correlation of alcohol and marijuana abuse; experiencing dysfunction between education aspirations and expectations for attainment of these goals; and from a family environment lacking in intrafamilial socialization, supervision, and outward expression of warmth and affection."

As programs come to recognize the need for culturally sensitive treatment for children and adolescents of color, programs will increase their flexibility and adapt their treatment and care modalities to better serve and treat our children of color. Lefley and Bestman (1991) describe a sixteen year history of a unique community mental health center which developed teams serving discrete ethnic communities.

The team staff - social scientists, clinicians, and paraprofessionals all of matching ethnicity to the populations served became a core of "culture brokers". DMH Child/Adolescent treatment providers and the DMH Child/Adolescent Division has estabished integration of culturally sensitive services into the daily life of the programs that serve children and adolescents of color.

Barrier: Negative Self Identity

Children and adolescents of color who are consumers of mental health services are challenged in their struggle to form a positive self image. Providers must recognize that failure to provide these children with ample opportunities to form a positive self identity may further contribute to the negative self worth that many of these consumers struggle against. Some times the unconscious message that gets communicated is:

> "If you deny yourself and who you are, you can get help at this treatment program. If you, the child of color, can assume "our values" you will benefit more from the treatment offered here".

These types of messages often get labelled as subtle, but when one feels pressure to not be themselves, what is subtle about that? Often the message that is loud and clear is that the child or adolescent of color will have to "blend in" if they are going to benefit from services. Providers must recognize and understand the potential to feed into and perpetuate a negative self image in some children and adolescents of color. Programs must help consumers of color cope with anxieties and fears of being different.

Children of color and their families have a harder time forming therapeutic alliances with programs when they do not see staff persons with whom they can naturally and easily identify with and trust. Many of these families have past negative experiences with institutions and may associate the program with other insensitive institutions and authority figures.

Barrier Buster: Positive Self Identity

The barrier buster for a negative sense of self is developing a positive self identity. Providers seek to help clients form a positive self identity through appropriate role models, consisting of: representative staffing patterns; using consultants and evaluators of color; and recognizing heroes of color. Providers help clients with several identity questions. Who am I? What am I as a person? How do I fit into the world? Our consumers of color have an important need to understand, accept and appreciate who they are. These consumers must consistently receive messages that enhance their sense of value and worth. Providers recognize that children of color may have a more difficult time forming a positive self identity, and, therefore; the corresponding response should be greater.

Providers recognize the increasing need to recruit, hire, appropriately supervise, and promote staff of color. Representative staffing must be evident at all staffing levels (front line, supervisory, clinical, consultants, management, and, administrative). Part of meeting this goal is breaking through the "buddy and good ole boy networks" that have been traditional avenues for recruiting, hiring, and, especially, promoting staff. Having staff of color is one of the strongest statements that a program can make to consumers of color and their families that they count and that their needs are important. As providers address the issue of hiring staff of color it is necessary to emphasize the importance of insuring that persons of color are also in decisionmaking positions (managers, etc.). A random survey of four DMH child/adolescent program follows: a) Program #1: 21% of current clients served were children of color, 13% of staff were persons of color, and 12% of the managers were persons of color; b) Program #2: 13% of the current clients were children of color, 7% of staff were persons of color, and 0% of the managers were persons of color; c) Program #3: 27% of the current clients were children of color, 30% of the staff were chidlren of color, and 24% of the managers were persons of color; d) Program #4: 20% of current clients were persons of color, 13% of staff were persons of color, and 0% of the managers were persons of color. Eighteen percent of the total staff of the Division of Child/Adolescent services are persons of color.

Many agencies voice frustration in their efforts to hire minority staff reporting that they "just can't find good qualified minority staff persons", despite their efforts to do so. This is an area where DMH and the Multi-Cultural Advisory Committee can play an important networking role. There are numerous strategies for recruiting, hiring, and promoting persons of color that some programs are using. A few strategies are offered here:

a) Recruitment: Efforts should be local, state-wide, and nationwide with activities such as networking with professional organizations of persons of color; advertising in minority periodicals and newspapers; school visits aimed at reaching out to minority students; networking with minority agencies (i.e. personnel maintaining a resource manual of multi-cultural agencies and sending copies of job announcements, which will increase the pool of potential applicants, especially for supervisory and management positions); offering Internships to persons of color; extending the recruitment process when no qualified minorities apply (often agencies are anxious to fill positions and quickly turn to traditional methods of recruitment which may not attract minority applicants); and participating in minority job fairs.

b) Resume screening: Closely supervising the resume screening process to ensure that qualified minority candidates are screened and receive an interview; and ensuring that minorities are included as part of the screening panel.

c) Hiring: A strong statement from the agency administrative executive and the funding agency regarding the importance of hiring persons of color; minority representation on the hiring panel; open discussions with staff with hiring

responsibilities to determine anxieties or apprehensions they may have in hiring persons of color. Some staff with hiring responsibilities report that they feel pressure to justify the hiring of a minority person, especially if they are "so-so", and they also fear that hiring a marginal minority person may be problematic later on if there is a need to fire the employee, fearing there may be allegations of racism; therefore all things being equal it is "less risky" to hire a marginal white person than a marginal minority. The perception is that there is less of a risk hiring the white applicant.

d) Promoting: A strong statement that persons of color be given strong consideration for promotions, including not always promoting from within the organization, but consideration of recruiting outside the organization particularly if there are no suitable minority candidates within the agency; using innovative job assignments which will allow staff of color opportunities to develop promotion skills, such as temporary assignments (day, week, serving an acting role in supervisor's absence, etc.), and assignments where the employee assumes supervisory tasks, responsibilities, and duties.

e) Evaluation of the hiring process: If a program continues to be unable to recruit, hire, supervise, retain, and promote persons of color, the question of racial bias must honestly be addressed by the organization.

As programs increase the numbers of staff of color, then they will more easily be able to help children and adolescents of color with their struggle to form a positive self identity. The child will have natural role models and persons to identify with in the program and will feel less alienated from treatment providers and will more easily feel accepted. The questions of who am I, what am I as a person, and how do I fit into the world will be more easily addressed when the child readily identifies with treatment providers.

Barrier: Low Self Esteem

As our consumers of color develop an appreciation of who they are, it is important that they also develop an appreciation and acceptance of their individual self worth. The self esteem of children and adolescents of color is constantly under attack, whether it be a litany of statistics, reports, or racial slurs that depict persons of color in a negative light. The foundations of racial attitudes are laid in childhood when the 'color value' of a community are absorbed. In societies with dominant White majorities, attitudes and values, including skin color values, are accepted by White and Black youngsters alike (Doku, 1990). If a minority child encounters a derogatory portrayal of his own racial group, he/she may begin to show a preference for the majority group (Milner, 1971). Treatment providers must understand this dynamic and help children and adolescents of color work through this process as they form their self identity and build self esteem.

Barrier Buster: Building Self Esteem

The best ways for our children of color to develop positive self esteem is through experiences which teach life skills, mastering difficult tasks, and finding areas of talent. Another way is helping children cope with inferiority feelings that they might have in response to living in a society that sends out numerous messages that the dominant culture is superior, helping the children and adolescents find within themselves those special things which will foster a greater sense of positive self and help eliminate feelings of being inferior. White staff members must have training which will help offset their fears, lack of knowledge, and lack of experience serving children of color and which will provide them with skills, knowledge, abilities, and confidence to effectively assist children and adolescents of color. Costantino et al. (1988) present a model using Puerto Rican folk heroes and heroines in a modeling therapy targeted towards enhancing adolescents' pride in their ethnic heritage, self-esteem and adaptive coping with stress. Lee (1991) presents a group counseling model for developing manhood among black male adolescents. The group begins with the showing of a videotape of successful African-American men in America. Lee suggests that his group counseling model is universal and can be used with Hispanic and Asian young men. Programs must ensure that positive daily chore assignments, leadership tasks, and opportunities for recognition are made available to consumers of color.

Barrier: Inability to Communicate

The barrier of staff inability to communicate with a non-English speaking child is a very difficult barrier for the child and their family to deal with. It establishes from the outset that the client is different from treatment providers and that they are ill-equipped to address the child's need. It is a situation that puts the child, their family, and the program at a disadvantage in addressing the child's mental illness. Language is the primary form of expression and communication that people have. When non-English speaking or limited English speaking children are placed in settings where providers cannot communicate with them, they may fear being discriminated against. Providers are unable to explain the program for the child, express understanding, offer consultation, and must struggle to provide any type of treatment. Many times programs employ interpreters to help communicate with patients, which is helpful, but usually this service is limited. At other times, the child becomes frustrated in their efforts to communicate their needs, wishes or desires.

With increasing numbers of clients coming from non-English or limited English speaking families, it is a must that programs have bilingual staff and qualified and trained interpreters available. According to 1990 census reports, over 31 million Americans speak a language other than English at home; over half of this number speak Spanish.

Barrier Busters: Bilingual Staff

Language is maintained and respected through hiring bilingual and bicultural staff; maintaining a roster of qualified interpreters; providing opportunities for the client to speak their own language; translation of program materials into Spanish and other languages; hiring bilingual saff through specific advertising; and having Spanish speaking staff on each shift.

Barrier: Racism

The barrier of racism is the barrier which is the hardest to discuss and address because of the highly emotionally charged way in which it is experienced, and the association there is between racism and hate. Racism is manifested through prejudice, stereotyping, discrimination, and racially motivated violence, which are areas which are not easily addressed. Providers of mental health services must recognize that racism influences self-image and that youth internalize the learned set of beliefs that legitimatize racism (Black et al.). Providers must help the child deal with and understand both blatant and subtle forms of racism. Treatments must appreciate the effect of discrimination, racial inequality, and oppression.

Barrier Buster: Understanding Racism

Clients are encouraged to express and discuss their feelings regarding racism. Providers help the child interpret and understand how experiences of racism can affect them, and to develop alternative ways of coping with the racial pressures of society. Community discussion groups have been used to collectively address these issues. Helping these clients understand the stresses of racial prejudice, discrimination, cultural alienation, and many other conflicts between and among ethnic groups becomes another way programs break through the barrier of racism.

Staff receive training designed to heighten their awareness of their stereotypes, biases, and value judgements as they relate to serving children of color. The program must provide a safe environment that enhances experience sharing and team building as programs break through the barrier of racism.

Barrier: Denial of Heritage & Customs

Traditionally, mental health services and programs have neglected to acknowledge, recognize, or celebrate customs and traditions which were not part of the majority group.

Barrier Buster: Maintaining Heritage

Programs encourage pride in heritage and customs through celebrating holidays and preparing cultural cuisine, and chronicaling historical contributions: celebrating the music, art, poetry, and writings of persons of color.

Another way for programs to demonstrate respect for the various cultures of the children they serve is to recognize and incorporate the values held within the community rather than attempt to assume the values of the dominant Anglo culture (Black et al., 1991). Additionally, the acceptance of folk beliefs and cultural explanations for illness is helpful.

Barrier: Disempowerment

The barrier of disempowerment leaves the child or adolescent of color feeling powerless and dependent on others to take control of their life.

Barrier Buster: Empowerment

Programs teach empowerment through having clients assume responsibility for their treatment through activities such as: leading community meetings and groups; taking a leadership role in treatment review meetings; being responsible for arranging appointments; involvement in the program evaluation process; and teaching responsibility.

DISCUSSION

As providers, to break through the barriers which have traditionally affected children and adolescents of colors' ability to fully benefit and access services they need support, encouragement, and constructive feedback from DMH. DMH must assume the important leadership role. Part of this role is clearly articulating values and expectations.

In preparation for this presentation, Child/Adolescent Program Managers and Child/Adolescent Program Directors have discussed the removal of the barriers to effective care during monthly program director meetings and during monthly program site visits.

In addition, as part of the comprehensive program evaluation, Program Managers and Program Directors have had discussions aimed at assessing where the Program was on the continuum of providing culturally competent services and working towards integrating these goals into the daily life of the program.

This study focuses on the barriers that children, adolescents and their families face once they enter the service system. As we know, persons of color historically have underutilized mental health services. Flaskerud and Hu (1992 define underutilization as a failure to seek treatment. Briones, et al. (1990) asserted that a recurring assumption is that underutilization represents one manifestation of the "general estrangement of the poor from the mainstream middle-class society and its social institutions". Despite roughly equivalent sociodemographic profiles and

similar diagnoses for Blacks and Whites, differences in utilization were found. Whites were more likely than Blacks to have participated in brief therapy, day treatment, activity therapy, and group therapy, as well as in a psychiatric day treatment program and in transitional care (Hu, et al, 1991. Underutilization defined in terms of retention of patients in treatment, according to therapist recommendations, has also been noted for African-American, Hispanic, and Asian patients, who have been noted to terminate treatment earlier than Whites (Armstrong et al., 1984). Another issue frequently raised is racial bias in the assignment of treatment. Armstrong et al. (1984) found that more Black than White patients were referred by the criminal justice system. Robinson and Johnson (1987) noted that the effect of deinstitutionalization in the Black community has been a significant increase in penal incarcerates. The Massachusetts Department of Youth Services reports that 64% of their total population in 1992 was minority, up from 42% in 1989.

As the mental health system increases its ability to remove "front door" barriers which will allow increased access to services for children and adolescents of color, care providers of mental health services must be prepared to provide culturally sensitive treatments. Acknowledgement and removal of traditional barriers to care will enable inpatient and residential program staff to deliver appropriate clinical treatment to children and adolescents of color which is culturally sensitive.

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ETHIOPIAN CULTURE

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COUNSELING

Traditionally, Ethiopian culture does not provide for Western-style counseling, i.e., mental health institutions, social welfare departments or private counselors do not exist in order to address the need for psychological counseling. Matters like a personal crisis or mental illness are always kept within the family and spoken of exclusively to close friends. If any member of the family goes through mental or financial crisis or has any serious matter in mind for which he or she requires counseling, the matter always stays with the famly.

The next stage is consultation among close friends. If a serious problem remains regardless of consultation such as psychosis or schizophrenia, something that family or friends are unable to help with, then the person involved goes to a folk healer for some kind of spiritual relief. They might also appeal to the church for help.

The pastor will counsel both patient and family and also administers holy water to afflicted persons during a kind of exorcism ceremony. The holy water does seem to have a sort of placebo effect in most cases, which is probably due to the deep faith of the patient common to most Ethiopians.

There are only two modern mental hospitals in Ethiopia. One is located in the capital city, Addis Ababa and the other one is in Asmara. However, the mentally ill almost always remain with the family and under their close supervision; sometimes they might even be chained to prevent them for harming themselves during a fit, but they continue to be taken care of in the family environment and until they die if necessary.

In this book, we find very unique case histories because each person has a different problem, although I am not saying that these are the only problems that Ethiopian immigrants face since there are many types of problems that have surfaced in their lives as they struggle to get used to life in such a completely different country. In this book, I have collected a few of the cases which might be of interest to the readers in order to illustrate the need for specialized psychological and physical help for Ethiopian refugees.

As mentioned before, Ethiopians are a suspicious and secretive lot, jealous to boot and very fond of intrigue. It is very hard even for competent professional psychologists to get to know the real personality of an Ethiopian patient. This type of behavior is mentoned in several books.

Let us mention the following quote from Professor Gebru Tareke (p. 14, Ethiopia: Power and Protest): "Both Levine and Gedamu Abraha have shown that the dominant traits of the Abyssinian peasant were secrecy, envy, distrust, jealousy, evasion, suspicion, ambiguity and mendacity - attributes that are actually characteristic of all cultivators living under similar exploitative systems of social production.

"Peasants, persistently faced with connivance of their neighbors, the insatiable greed of their superiors and unpredictable natural dangers, are forced to employ various defense and manipulative mechanisms to protect themselves from economic ruin and social indignity, or even to profit at the expense of their neighbors. So, the peasant tries to outwit by telling half-truths or by giving inaccurate information about his output or material possessions. His marked cautiousness or self-centeredness is an outcome of long experience of a world that he viewed as inhospitable. Insecurity created caution about human frailty that bordered on fatalism."

What is the use of writing this book? The main reason is to explain to professionals the problems most Ethiopians in the refugee camps and in new lands face so that these professionals might find a way to treat the symptoms in the proper manner after learning about their Ethiopian behavior and culture and give them directions in the new areas.

How does one counsel a paranoid Ethiopian? Can we follow the scientific theories of Freud or should we follow the theories of Prof. X? Which school of psychiatric thought should we follow in order to treat these special individuals? All I can say is that it is very difficult to treat them without first knowing the background of these individuals. Howevever, a particular scientific treatment can definitely be applied if one understands the Ethiopian background and behavior.

Ethiopian refugees have been in turmoil and have been through such terrible experiences that any one attempting to analyze them will encounter the same difficulties other psychologists are having now. These psychologically wounded people must by all means have the proper treatment and care in order to be effectively helped. The following suggestions and advice could be incorporated into your fund of knowledge about Ethiopian personality:

When you start counseling Ethiopians, you must see them on an equal basis and give them time to develop rapport with you as well as a close relationship between client and counselor.

If any Ethiopian client should start by wanting to discuss politics, whether they have a deep knowledge of the particular point or not, the counselor must totally avoid the discussion. Never tell the client things such as: "You are sick'" and by all means try to address him in such a way that he will not feel threatened. Avoid any talk or statements that will undermine his manhood such as: "Why don't you do this, are you afraid?" or "Why don't you comb your hair?" Simple things to be sure, but phrases that if to the Western ear sound like the advice that they are, to the Ethiopian male psyche are nothing but an imposition on their ways.

Ethiopian males have a tendency to treat their female partners as lower than themselves; so much so that they do not even call their wives by name, and when discussing a woman they will not mention her by name but only refer to a female as "a girl" in an indeterminate fashion, if you will. Ethiopian males do not see their women on an equal basis and therefore will not include a girlfriend or wife in any important decision-making. The important decisions are made by him and him alone. The woman will be informed of the decision after it has been taken by the man.

It is important for a counselor dealing with clients from traditional societies such as the Ethiopian to realize that in such societies the personal worth of a woman lies in her role as a wife and mother. Early marriage, women in the home and sex-stereotyped training have prevented females from participating fully in national development. Rights such as property and inheritance vary according to the ethnic group, i.e., among the Oromo, women cannot inherit but among the Amhara, a woman is pretty much the equal of her husband with regard to the ownership of land, property, and rights to institute divorce proceedings.

In urban areas, educational and occupational opportunities have provided some women with roles outside the home although their social position remains largely unchanged.

According to Zenebework Taddese, an Ethiopian woman writer, the communist dictatorship "failed to facilitate the transformation of the subordinate status of women" in spite of its heavy volume of Marxist rhetoric to the contrary.

Those who actually took the first effective steps toward women's emancipation in Ethiopian society were the guerrilla groups of the late 70's and 1980's such as the TPLF, EPRP, EPLF and others which admitted women in their ranks for combat duty. Many a traditionally-brought up young Ethiopian woman, with her life threatened and her nearest and dearest murdered by government violence joined the guerrillas and did quite well at it too. The community military never allowed women in their ranks.

Ethiopian refugee women in the United States have mostly kept the behavior patterns and values of the "old" Ethiopian culture although they are all under transition toward adopting Western culture and values. Any counselor treating

Ethiopian refugee women must therefore take the following guidelines into account:

1)   It is very difficult for Ethiopian women to discuss sexual matters with a male psychologist or counselor.

2)   Ethiopian women are always influenced by the males nearest to them such as the husband, father, or brother.

3)   The family always comes first for Ethiopian women responsible for running a home and taking care of very young children.

4)   Due to the passivity and submissiveness expected of females in Ethiopian culture, an Ethiopian refugee woman is still very susceptible to male authority figures although she would always be reluctant to express her true feelings to any counselors, male or female.

5)   Although the younger Ethiopian refugee women rebel against their native cultural expectations of almost total passivity for females, they still expect to be treated as Ethiopian women.

6)   An Ethiopian refugee woman is more likely to be less educated than the male.

If an Ethiopian male shows up to receive counseling from a therapist before a strong client-therapist relationship has had time to develop, do not give suggestions in the vein of: "Who do you think you are?" or "Why don't you share more with your wife or girlfriend, etc.?" Above all, do not dare put down or criticize Ethiopia as such. If you want to mention Ethiopia, do it in this indirect fashion: "What went on in your country is truly a terrible thing. What can you tell me about it? Could you tell me more about what happened?" Then the client will volunteer information about his or her country.

When counseling Ethiopian women, mistakes such as the following should be avoided: overlooking the woman's cultural background or overgeneralizing from the group to the individual such as assuming that all Ethiopian women are submissive and passive or expecting them to begin the counseling process without consulting the family or discussing intimate details of her sex life before rapport has been established.

The counselor should try to provide support and understanding for the traditional Ethiopian female role and at the same time encourage female clients to make independent personal decisions. He/she should also try to become acquainted with family members, mainly the males who are so influential in a woman's decision making.

A counselor must also aim at providing Ethiopian female clients with information about vocational opportunities and training in order to assure her economic independence and self-sufficiency.

It is important for counselors to note that Ethiopian refugees in the US are an ethnic group about which the American public knows very little. Americans (both Black and White) look upon Ethiopians as Africans first while Ethiopians see themselves as Ethiopians first and foremost, regardless of color. Some Ethiopians go as far as describing themselves simply as Tigreans, Amharas or Oromos in light of their ethno-linguistic origins while others call themselves Eritreans, Somales or Oromos according to their political views.

Although most educated Ethiopians are strong supporters of pan-Africanism, they still view themselves as Ethiopians first and black or Pan-African second.

Ethiopian refugees in the United States are attempting to exist in a society in which race is still often a crucial element and as a result, they may suffer from the conflict between self-perception and preferred identity and the external perceptions and identity idealized by American society.

While trying to adapt to American culture, Ethiopian clients seem to waver between identities by adopting behavior patterns such as speaking their native language to insure ethnicity or even identifying with the Black community in order to be more easily assimilated into mainstream America.

A competent counselor should not assume that an Ethiopian client belongs to any particular racial or cultural group and should allow the client to explore his/her identity issues in his/her own way. Instead, the counselor should try to understand and support the client's interaction with other Ethiopians while being aware that racial identity crisis and stress are inflicted on Ethiopians by local racism.

Since an Ethiopian client's first experience with racism might well be with American racism, a counselor must try to be discreet while discussing racial issues and avoid making mistakes such as assuming that because Ethiopians are dark skinned they must identify with Black American culture. Above all, the counselor must never avoid discussing racial issues in order to prepare the Ethiopian client for a successful exposure to American racism or the issues of race as they affect everyday life i.e., job discrimination, personal relationships and the forming of identity groups.

BARRIERS TO SERVICES WITHIN THE FORENSIC MENTAL HEALTH SYSTEM

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INTRODUCTION

In 1987, Center for Health and Development, Inc. (CHD) launched its involvement in delivering mental health services within the Forensic Division of the Department of Mental Health. Since that time, CHD has been at the forefront of assisting in the development of the service system for clients within the forensic arena and has been influential in setting the standards for psychologists who practice in this specialty area. To be sure, the many challenges faced by people of color within the broader mental health system are represented within the area of forensic mental health. Given the constant and unavoidable interface between psychology and the legal system within the field of forensic mental health, there are frequently new dimensions of old difficulties and obstacles which must be addressed. Although these issues are often the subject of considerable intellectual debate, daily interactions with the "real players" makes it all too clear that the consequence of the absence of some "real" solutions to a myriad of difficult problems continues to result in "real" pain.

This paper seeks to integrate both theoretical and clinical issues using case studies for illustration. The case studies were chosen for their ability to superimpose an indelible cloak of humanity upon a body of information which deserves our most serious consideration.

HISTORICAL PERSPECTIVE

Major efforts to improve mental health services for all Americans began in the 1960's, but the mental health system continues to struggle with providing services which are appropriate, accessible, culturally sensitive, and linguistically responsive to peope of color. Racial descrimination and low-income status represent serious barriers to access and may result in the systematic exclusion of people of color from the very systems on which they depend for help.

Past research has shown that people of color are: more likely to receive qualitatively inferior or less preferred forms of treatment (Acosta, 1980; Cooper, 1973; Gilbert, 1973); more likely to receive institutional rather than community-based care (Cannon and Locke, 1977; Sharpley, 1972); more likely to drop out of treatment because of dissatisfaction with care received (Sue et al., 1974; Warren et al., 1972); more likely to be seen for diagnosis only and inappropriately diagnosed

(Jackson et al., 1974); more likely to be treated in public rather than private facilities (Cannon and Locke, 1977); more likely to be cared for by paraprofessionals (Sue et al., 1974); and more likely to encounter procedural, cultural, language and financial barriers to treatment (Gilbert, 1972; Warren et al., 1972). While there have been some improvements in the public service delivery system since the 1970's and 1980's, inequities remain.

Historically, within the public sector, there are disproportionate numbers of consumers who are disenfranchised, economically deprived, homeless, and uninsured. Many clients present with multiple problems and chronic impairment. Ethnic minorities face the added burden of racial discrimination from the majority culture. They may also be faced with a scarcity of resources within their communities so that their issues may have never received the level of intervention needed to provide a more long-term solution to their problems. Furthermore, consumers of color cannot assume that the clinician who is assigned to meet their needs will share a common cultural background or even acknowledge the ever present and critical impact which ethnicity plays in the art of daily living.

Clinicians of color are few in number and there are some cultures for which there is no professional representation in the forensic area. This can be especially troubling as the presence of clinicians of color can at a minimum serve to keep issues of diversity "on the table", forcing that some acknowledgements be made of the added complexity which is often imposed. In fact, the assumption of diversity is an important one which majority clinicians may not always integrate into their decision making and understanding of a client's symptomatology. If individual differences are narrowly conceptualized within a Eurocentric model, people from other ethnic backgrounds can be at a distinct disadvantage. Clinically, misdiagnosis due to under- or over-pathologizing is less than optimal in providing interventions which are maximally therapeutic.

Within the forensic arena, the stakes can be exponentially higher due to the very real implications which a client faces through the legal system. Historically, people of color have felt at some disadvantage within the legal system. Those who present with clinical symptomatology may be particularly at risk for misdiagnosis if cultural differences are not understood and taken into account in moving towards a point of resolution. For example, in Hispanic culture, symptoms of depression can present as more agitated than labile and in this form are referred to as "los attaques." These "attacks" present very much like a seizure and are an attempt to contain anxiety, anger, and depression. Medical professionals often consider these "attacks" to be fake seizures as there is often no neurological basis for the seizure-like response. Those who do have a neurologically based seizure disorder may continue to experience the "los attaques" intermittently. To further complicate the issue, during the "attacks" there is random movement with the potential of being struck. This behavior may be viewed as assaultive and the accompanying penalties may be imposed.

Another such cultural dilemma is raised with the Asian client who is involved with the legal system after a fatality occurs due to the use of martial arts. Within the Asian community, martial arts are only to be used for the purpose of self-defense. To use this art form to aggress against another brings disgrace to the community. The disgrace is righted through the elimination of oneself. An ethical dilemma is therefore presented in the case of a patient who presents with amnesia for his involvement in such an event since bringing forth his memory puts him at substantial risk for suicide.

As professionals within the forensic mental health system, there are presses from multiple sources including legal, mental health, and one's own personal and professional ethics and morality. For professionals of color who try on a daily basis to operate in a manner which takes into account the ethnicity of the clients before them, there is the added risk of alienation by majority peers who do not share their level of investment or understanding for the issues at stake. The risk incurred here can be significant as the forensic mental health "fraternity" is an important support network which can be critical in this high stakes specialty area. Expanding the network of clinicians of color would be one means of bringing more visibility to the issues faced by clients of color within the service system.

OVERVIEW OF TREATMENT ISSUES

There are some substantial barriers to treatment for adult minorities who are court involved and served by the clinician of the Division of Forensic Mental Health. These impediments are not all systemic and some lie within the patients themselves. Specifically, a significant obstacle is the suspiciousness and mistrust that minorities often have for government institutions, particularly the criminal justice system. Court clinics and their staffs are perceived as an integral part of this system, which is frequently viewed as unjust and oppressive. Consequently, this often makes it difficult to establish working alliances for evaluations or treatment.

Of course, the relative lack of minority staff or other individuals trained to deal sensitively with multi-cultural issues contributes to the limitations of potential treatments, even if they are available. Moreover, many of the clients of the neighborhood courts and clinics suffer from chronic mental illnesses, long standing personality disorders and historically abysmal adaptations to life which by their natures have been quite refractory to treatment and rehabilitation. Importantly, the dramatic increases in arrests and arraignments puts inevitable stresses and strains on the court based mental health delivery system. Thus, the sheer level of need alone poses a barrier to treatment. This is further compounded by the urgency to recognize that people of color often present with life histories, experiences, and mental health issues which differ conceptually from the mainstream, dominant culture.

It is customary to see quite varied and "exotic" clinical cases in the various court clinics. However, several diagnostic groups predominate. It should be emphasized that these patient groups have a great deal of overlap with each other. By far, the predominant group is that of the alcohol and substance abusers. The chronically mentally ill are another salient group. Unfortunately, these individuals are often struggling with alcohol and substance abuse as well.

The second most common group is composed of "violent" individuals. In that sense, it is extremely rare for a person to be arraigned on a criminal charge involving violence which is not alcohol and/or substance abuse related. Indeed, cases sometimes involve the more well known cases of the male serial batterer on his female partner, but also more frequently involve violence between parents and children, siblings, neighbors and friends. Fortunately, the great majority of these cases involve sub-lethal violence which rarely results in serious injury. Accompannying this group are the victims of violence and relatives and friends of victims of violence.

Despite the epidemic of violence in the community, there are no community based programs for people who batter (primarily men) and there are only a very few programs for victims. It is not unusual for a victim or perpetrator to disclose that they had family or other close interpersonal ties to as many as six or seven murder victims. The frequency of other crimes causes considerable trauma and a serious clinical concern emerges in considering how many people in certain high crime areas suffer from some measure of post-traumatic stress. Specialized services outside the community for which these individuals would be appropriate, are often expensive or require the "right" insurance.

The majority of clients seen by neighborhood court clinics are addicted to alcohol or drugs, frequently both. As a result, the most common commitment proceeding is the thirty day involuntary commitment to a substance abuse facility under Sec. 35 if failure to hospitalize would result in substantial harm to the person or others. Males are invariably committed to the Bridgewater Addiction Treatment Center. Clinical experience strongly suggests the need for long term residential rehabilitation which is very limited. As a result, many individuals quickly relapse after their discharge from Bridgewater since outpatient alcohol and substance abuse services are not always sufficient to assist in continued sobriety and abstinence.

CLINICAL CASE ILLUSTRATIONS

Michael B. is a 30 year old single African-American male who is a high school drop-out and chronically unemployed. He has been intravenously addicted to heroin and cocaine for ten years. Mr. B. has been committed to the Bridgewater Addiction Treatment Center three or four times in recent years but after his discharge, despite his most valiant efforts, he relapses after several weeks. He has tried outpatient programs including acupuncture, but this just hasn't worked for him. He has been

on waiting lists for half-way houses but after a couple of weeks, he gives up hope and succumbs to his addictions.

Because the Addiction Treatment Center is a locked facility, male patients, at least, are assured of at least thirty days of sobriety and abstinence which gives them a "running start." However, female alcoholics and substance abusers often never get to this point in their treatment course. Thus, at the outset, they are thwarted by the lack of programatic support for any movement toward even considering long term residential placement which as for the men is at a premium. For example, Jane D. is a 25 year old single woman whose four children are in the custody of the Department of Social Services because of her seven year history of heroin addiction. Jane is constantly arraigned in the area courts on charges of prostitution and shoplifting. In recent months, she has been committed to local substance abuse facilities three times under Sec. 35 but has left these facilities often within days or literally hours after being brought there by the sheriff's department.

Even attaining a bed as far away as Fall River does not deter her from leaving. Meanwhile her addiction escalates from $300 to $400 a day. Ms. D. is HIV positive and her preoccupation with hustling money and buying heroin hinders her from proper medical follow-up and treatment. Her desperation drives her to ignore safe sex practices which puts the community at large at considerable risk for spreading of her communicable and deadly disease.

The lack of locked substance abuse facilities for women is a significant obstacle for addicted and alcoholic women served by these inner city courts. Obviously there are well motivated women who would like positive change, but are so out of control that only a locked facility would give them a "fighting chance." Finally, as with the men, there are limited beds available for long term residential substance abuse and alcohol treatment.

The mentally ill patients seen by forensic clinicians are generally suffering from chronic paranoid schizophrenia. Many with the assistance of SSI Disability and the support of their families, are able to maintain a somewhat fragile but comfortable life. With day activities, compliance with neuroleptic medications, case management, and supportive psychotherapy, they are able to remain ambulatory and reasonably asymptomatic. Like non-mentally ill individuals in the community, they too have been exposed to the lures of drugs, particularly "crack" cocaine. Crack addiction assuredly is highly destructive for anyone, but has especially pernicious effects on persons with schizophrenia. Once addicted, these individuals, with less ego strengths to begin with, deteriorate swiftly. The combination of the two conditions make them very difficult to treat and serious disposition questions emerge.

Jim W. is a 35 year old man whose first inpatient admission for schizophrenia was fifteen years ago. He has been living on SSI Disability and living with his mother for the past seven years. In the first eight years of his illness he was

hospitalized only two times and seemed to do generally well on his anti-psychotic medication. Four years ago he developed a cocaine addiction. Since then he has been arrested many times for threats, trespassing, malicious destruction of property, and more recently, violation of restraining orders as his mother has become weary and frightened of his harassment of her for money to purchase cocaine. His SSI check is spent on cocaine the day he receives it. Now he is homeless and has stopped taking his medication.

Thus, in the past four years he has been admitted or committed to the local community mental health center six times and has been committed to the Bridgewater Addiction Treatment Center several times. From the point of view of disposition, it is often difficult to ascertain on any particular morning in the cell block if his addiction or mental illness contributes most to the clinical picture. As a result, there is frequent controversy as to where he should be. At various times, he is perceived as inappropriate by either the mental health facility or substance abuse center and undergoes what could be construed as premature discharges. Jim is involved in a revolving door cycle of admissions and discharges while his psychological status continues to worsen.

In addition, there are mentally ill patients who do not abuse alcohol or drugs, but the brittle nature of their chronic mental illnesses are such that short term voluntary and involuntary admissions are of brief benefit. A significant barrier to treatment for these patients is the lack of long term inpatient beds.

In recent years, there has been a dramatic increase in immigration from many nations to the Boston area. Minorities and recent immigrants who speak little or no English are at a distinct disadvantage relative to participation in criminal proceedings they face as well as the shrinking, sometimes to non-existence, of treatment possibilities. Thus, the cultural differences are further complicated by language barriers which can have a negative impact on the assessment process as well as any interventions which might be put into place to assist the person. As immigrant communities are beginning to mobilize around mental health issues, it is critical for professionals from other cultures to actively seek out opportunities to interface and dialogue with them around diagnostic and treatment issues.

Jean R., age 46 and his wife and two teenage daughters were referred to the Court Clinic for a family evaluation after he was arrested on assault and battery charges against his wife and daughters. Mr. R. was recently laid off from his maintenance position and increased his alcohol consumption. These are precipitants beyond the stresses of cultural transition which contribute to the present family discord. A recent immigrant from Haiti, Mr. R. speaks only Creole French. His wife has limited proficiency in English. His adolescent daughters speak only English. A French interpreter was unavailable for the emergency. The assessment dilemma is overwhelming and obvious.
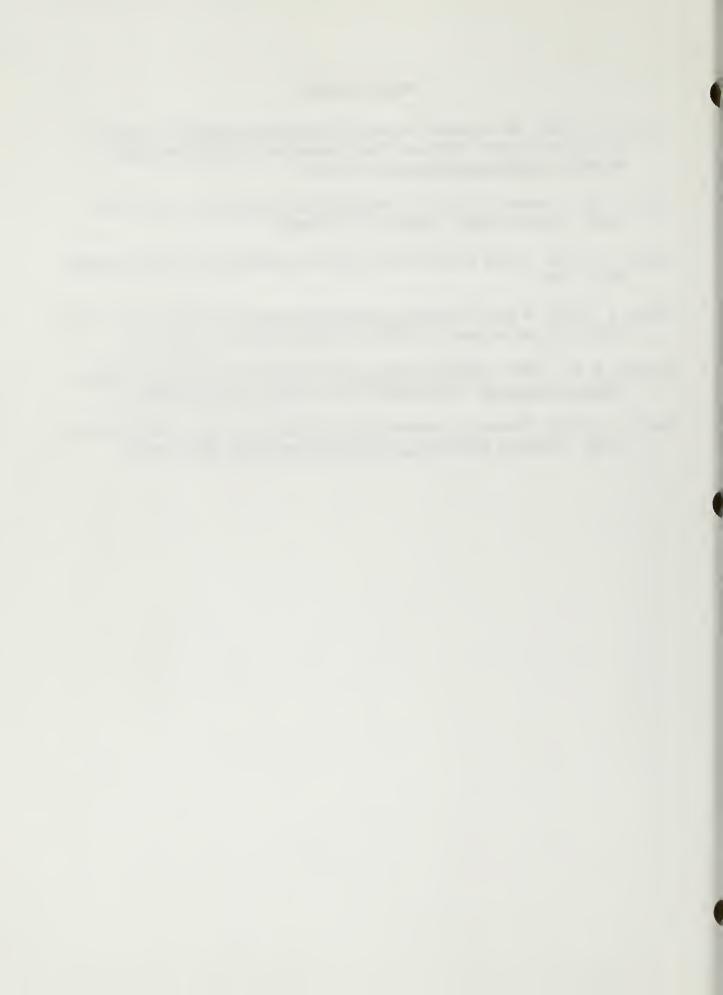
SUMMARY

Over the years, CHD has shown a willingness to challenge and revisit some of the broad assumptions which operate within the field. We are ever aware of the need to do this within a context of sound clinical judgement and scrupulous professional ethics. CHD also takes its commitment to cultural diversity among staff very seriously and the efforts towards this end are visible at every level within the organizaton. Professionals from all cultural backgrounds are valued and supported. The consideration and incorporation of cultural norms is a part of any service model put forth by CHD and innovative approaches to treatment are encouraged. Such constant attention to cultural issues seems warranted given the tremendous stakes involved when clients enter into the forensic mental health system. We owe every client the most clinically appropriate and culturally competetent consideration that can be offered. Understanding and integrating issues of ethnicity will always be a critical component of a competent mental health evaluation.

Becoming more culturally competent is the challenge for all of us since the diversity of ethnic backgrounds within the US population insures that none of us can claim full awareness of every cultural experience. Beginning to ask questions of other professionals of color is an important first step as this is outward acknowledgement that there may be something more to be learned. Fortunately, talking about cultural differences has become more acceptable and "en vogue", leading to increased visibility. This should serve to promote a higher level of cultural awareness and appreciation among professionals who can ill afford a stance of ignorance.

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SIBLING THERAPY WITH LATINO CHILDREN IN FOSTER CARE

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The ideas that I will be presenting to you were developed by the Hispanic treatment team at a child guidance clinic. I will begin by describing what lead us to begin doing sibling therapy. I will explain the theoretical underpinnings of our approach and some of the techniques and activities we use in working with sibling groups. I will conclude by briefly presenting two cases to illustrate the usefulness of this model in addressing issues common to abused children.

Our clinic receives a great number of referrals for treatment from the Department of Social Services, which is the child protective agency in Massachusetts. Our approach to serving these cases is one that usually involves the whole family, but a few years ago we received a number of referrals of several siblings in families who had been involved with DSS for a number of years and whose parents were not available to participate in treatment. The reasons for their unavailability were varied; some were incarcerated, others had been offered services throughout the years and had not made use of them and it did not appear that the children would return to live with them.

We noticed several commonalities in these sibling groups. First there were usually 4 or more siblings per family, they were rarely placed in the same foster home, and they saw each other infrequently. Also, as is typically the case with children in foster homes, many of their presenting problems responded to the feelings of loss created by the separation from their families. Some of the children were placed in non-Hispanic foster homes so there was even a loss in terms of culture which included foods, traditions, holiday celebrations, etc.

Our first obstacle in trying to respond to this request for services was a pragmatic one. Being the only agency in Central Massachusetts with a team of Latino bilingual child therapists, we were faced with the dilemma of either assigning each individual child an individual therapist, which would mean putting a lot of resources to work with a few families while others waited, or to find a different solution. That's when we decided to try seeing the siblings as a family group even if there were no parents involved. From a therapeutic standpoint we felt that it would give them an opportunity to see each other, and to process what

was happening in their families. From a cultural perspective, we believed that this was appropriate since the children had grown-up in a culture that values extended family involvement. Also, as a group of Latinos, it was our perception that sibling relationships in our culture were typically closer than in this culture and that alliances among siblings were not necessarily determined by age groupings.

Theoretically, we base this model primarily on systemic, structural and object relations theories even though we utilize techniques and activities from a broader set of approaches. We believe that by seeing the sibling subsystem together we are able to better understand each child's behavior within its relational context. Our overarching goal in working with the sibling group is to strengthen the bond among the sibling subsystem and to help them learn to become a support system for all the children in the family. Our rationale is that since their nuclear family has been broken, the siblings can provide a sense of identity and of belonging to one another. We also believe that early object relations are very significant and that children's styles of relating are greatly influenced by early life experiences. We see the therapeutic relationship in working with these cases as an attempt to provide a corrective experience for these children. With this in mind, we assign the sibling cases to a team of male-female co-therapists. The therapists are very intentional in their interventions in modeling a balance of power between the genders by showing a range of characteristics such as: authority and leadership, sensitivity and consideration, as well as joint decision-making. In most cases, a discussion about expected male-female roles is elicited by a question the children bring to the therapists at some point in the treatment. We believe that these questions may be in response to the dissonance experienced by the children between the therapists' relationship and their previous experiences of male-female roles in which males dominate and females are oppressed for the most part.

I will now proceed to describe the treatment process. The initial sessions are unstructured to allow the therapists to observe and assess the quality of sibling interactions; are they hostile/violent? Is there sibling rivalry? Are relations supportive?... We also pay attention to the siblings' understanding and reactions to their family's disintegration. During these sessions we look at the roles that each child plays within the sibling group, that is, is there a parentified child? a scapegoat? a traitor? a perfect child? a clown or distractor?, etc. Alliances, coalitions, or disengagements among the siblings are also noted in the first two to three sessions. These sessions are usually pretty disorganized and chaotic due to the excitement the children feel about being together, to their discomfort or anxiety about being in the therapy situation, and often to their feelings of responsibility to keep certain things secret and needing to monitor others to keep them from disclosing some things about the family.

Frequently, the children are very aggressive towards one another both physically and verbally which begins the limit-setting function of the therapist. Much like in group therapy sessions, we usually involve the children in deciding about the rules for the sessions.

After the first two or three assessment sessions, the sessions become semi-structured. We, the therapists, plan an activity or two alternative activities for each session that will address some of the issues we observed during the assessment period. All of the activities have in common the goal of helping the children learn to work together in a positive, cooperative, supportive manner. Drawings are frequently used; individual and group drawings can be used to represent feelings about common experiences, to depict perceptions of a particular person, to depict perceptions of the whole family, etc. After doing the drawings, each child shares and explains his or hers to the group. This is helpful in learning to understand differences, to clarify what each person believes about what has happened to the family. We also have found group drawings to be a good way of fostering team work. We will bring a large piece of paper and not enough crayons or markers for all the children. We instruct them to decide as a group what the drawing will be about, who will draw what part, in what order will they draw, etc. This is initially met with some resistance, but eventually has led to some of the most interesting and positive interactions and drawings we've seen. We encourage the same type of cooperation in building something out of blocks; sometimes we assign or they choose separate but interdependent tasks. For example, someone will be the architect who will draw the design on the board; someone will be the supplier who will deliver the right sizes and shapes of blocks; and someone else will be the builder. Another type of activity we use and that is probably the one children like the most, is role-playing, and enactments. The themes can be past, present or future depending upon what issues we are trying to address. Each sibling has the opportunity to be the director and to assign roles and actions to the other siblings and to the therapists. After each role-play, we process it with them and each person gives feedback to everyone else. We have seen accurate and dramatic enactments of behavior of adult figures in their lives and of abusive situations that we would not have known about if we had asked the children to describe them directly.

Often times, we will ask them to repeat the role-play but with the way they think it should be or wish it would have been. This second part encourages mastery of the situation, calls for practicing newly learned skills and has some of the same goals as the therapist's stories in the mutual story telling technique. We also use the mutual story telling technique, but with each child taking turns in adding the next line to the story. Social skills training sessions are also frequently used since this is a common deficit amongst the children. We try to make the sessions fun by participating ourselves and usually acting out the incorrect versions of the behaviors we are targeting. The children typically find this very funny and it creates a positive humorous environment to the task at hand.

These are some of our most widely used activities but the lsit is endless and we seem to develop new ones in response to each sibling group's needs and characteristics which include: age, gender, number of children, type of abuse and presenting problems. We have done outdoor activities such as playing softball,

doing races as well as more traditional ones such as group discussions, communications skills training, dollhouse play, etc.

I hope this discussion gives you a good idea of what this work looks like. We have used this model as an adjunct to individual therapy as well as the single treatment modality provided. We have found it very difficult to work in this model when the biological parents continue to be involved with the children and strongly object to their children's participation in therapy.

Now, I will briefly describe our work with 2 cases to illustrate the usefulness of this model in addressing some common therapeutic issues of abused children. While we dealt with many other problems in the treatment of these two cases, I have chosen to discuss specific issues in the interest of time.

The Perez-Ortiz Siblings

This sibling group was composed of 5 children, 2 boys and 3 girls of Ms. Ortiz and five different men who had never been involved with their children. At the time we began our work with the children, Mrs. Ortiz had been incarcerated on 2 occasions on drug-related charges for a total of about 3 years. The second to the oldest boy was never involved in therapy with us because he was placed in a residential program in a town far away from our clinic. The oldest boy participated for a few months but then was also moved out of the area. Most of our work was with the three girls aged 9, 8 and 7. At one point in the therapy, we focused on their sexual abuse by a teenage cousin which occurred about 4 years before. With our help, they talked about what had happened and about their feelings about it. We also did some sexual abuse education with them. Shortly thereafter, they began to express to me their wish not to have the male therapist in the sessions. I told them I thought it was important for them to tell him how they felt and helped them plan to voice their feelings to him and suggested that they could help each other say it. They did and the male therapist responded by validating their feelings and thanking them for their honesty and their courage. He also stated that their feelings were very important to him. At that point, we planned that the male therapist would take a more distant/less active position in the sessions and that he would ask for permission to participate in activities, etc. We also planned that I would act as the intermediary and would check with the girls about their feelings and about whether they wanted him to join in an activity or not. After several sessions, we began to notice a difference in the way in which the girls related to the male therapist; they began to include him and to invite him to participate especially for those activities in which he had better skills than I did. Later on, you could see their genuine enjoyment in having him participate.

We felt that the opportunity to interact with a gentle, caring, non-controlling, understanding male figure, and a responsible, active, protective female provided a corrective experience for these girls in which they were able to work on some issues

related to males and females in their lives as well as to their sexual abuse experience.

The Rodriguez Siblings

This was another group of three sisters referred by the Department of Social Services after the girls were removed from their extended family's home due to serious neglect and emotional abuse. There were also some indications that they had been sexually abused by an uncle. The problems identified by the referring person were: oppositional behavior for all of the girls; poor impulse control, and extreme attention seeking behaviors in the middle child; stealing by the oldest child; and withdrawn behavior by the youngest child. During the assessment, it was noted that these girls were abusive towards one another, that they could not work together on one activity at a time, that they competed for the therapists' attention and that the middle child was very controlling and manipulative towards the other 2 who were in alliance and in turn, rejected the middle one.

The treatment was designed to first, reorganize the sibling subsystem so that they could interact in more positive ways by teaching them how to express their feeling and opinions, how to ask for what they need, how to listen and respond to one another, to give praise to one another, to acknowledge their differences, to solicit opinions and cooperation from one another, etc. This was mostly accomplished by doing role-plays and puppet play in which they had the opportunity to experience different roles, and to practice doing things incorrectly and then correctly. Play-acting is a technique we have found most children enjoy and get thoroughly involved in. After several months, positive changes were noted in the girls behaviors: Ana, the middle child is doing better in school and is able to be considerate and to yield to what others want to do instead of imposing what she wants. Her sisters notice and verbally praise Ana for doing that. Maria, the oldest has learned to be more assertive. Teresa, the youngest one is less withdrawn and can focus more on herself rather than passively following others. The girls are not reported to display oppositional behaviors.

I hope that these examples have given you a flavor of what our sessions with the sibling groups look like. The sessions with the sibling groups are just part of our treatment plan. Close contact and communication with the protective worker and the foster parents is essential to the success of the treatment. We need to be informed of changes in the status of the case: are any of the children going to be adopted? Has the family relinquished parental rights? Is the family requesting to re-initiate visits? These changes affect each child and their relationships and require changes in our treatment planning.

The quality and extent of our relationship with the foster parents is probably one of the most determining factors in terms of how well the therapy proceeds. We need to have the foster parents' cooperation and collaboration in providing continuity to what we are trying to accomplish in the sessions. We also provide

support for the foster parents who frequently experience great stress in their very difficult job with these children. We also need their observations of the children at home to assess the impact of our interventions and to plan for new ones.

In most cases, close contact with the children's schools is also important, again to obtain information as well as to provide consultation to teachers.

To summarize, we have found sibling therapy to be a useful and effective approach to treatment of abused children in foster care. Since we began developing this model, a few articles have been published that confirm our work and expand the use of sibling work to other problems and population groups (Lewis, 1986, 1988a, 1988b; Nichols, 1986; Schibuk, 1989). We hope that this discussion will generate in you an interest in adding this type of treatment to your repertoire. Thank you.

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MULTICULTURALISM IN A PUBLIC PSYCHIATRIC FACILITY

by Errol Rambarran and Rajoo Ananth

Introduction

Ten years ago a new employee in a public psychiatric facility might have been told that his/her chances of succeeding and advancing will be improved if he/she can fit into the existing culture. In 1993, a progressive manager is likely to say that the facility is interested in your cultural values, your background, your attitudes and your priorities in life; that we want to create the kind of environment that will enable someone like you to achieve and contribute as much as possible. In just a decade, the message to employees entering the workforce has changed from "assimilate into our corporate culture" to "share your individual culture with us". But in reality has this message reached large bureaucracies like public psychiatric facilities whose managers are untrained in cultural diversity or are unwilling to embrace the tenets of cultural diversity?

Equal Employment Opportunity legislation and legal precedents on discrimination demand that yesterday's managers approach their supervisees with the idea that "We are all equal. Let's cooperate". Changing demographics and an increasingly multicultural workforce by the year 2000 are requiring today's managers to say, "We are all different. Let's capitalize on those differences".

The Hudson Institute in its workforce 2000, concluded that minorities will comprise a larger share of new entrants into the labor force as indicated in the charts below:

THE NUMBERS OF DIVERSITY

TOTAL WORK FORCE (IN MILLIONS)

NEW ENTRANTS
TO THE LABOR FORCE

Net New Workers 1985-2000:
25,000,000

☐ Native White Men

☐ Native White Women

☒ Native Non-White Men

☒ Native Non-White Women

☒ Immigrant Men

☐ Immigrant Women

Source Hudson Institute

As such, the impact of these demographic changes will precipitate a challenge of managing a multicultural workforce.

This paper examines this challenge by a review of multiculturalism in a public psychiatric setting through case studies and workforce analyses.

Workforce Analysis:

In the public psychiatric facility examined the following data emerged.

1. Of a total of 34 managers, 2 are minorities - 5.88%
2. In a total of 26 Nursing Supervisors, 0 are minorities - 0.0%
3. In a total of 16 Core Supervisors, 0 are minorities - 0.0%
4. In a total of 12.8 Psychologists, 0 are minorities - 0%
5. In a total of 21.5 Social Workers, 0 are minorities - 0.0%
6. In a total of 31.4 Area Operations Staff, 0 are minorities - 0.0%
7. In a total of 76 Supervisory Personnel, 2 are minorities - 2.63%
8. In a total of 3.3 clinicians, 0 are minorities - 0.0%

A further examination of departments revealed a complete absence of minorities in the department which upholds AA/EEO regulations and no minorities among executive staff.

CASE STUDIES

A. **Black Female Manager**

A Black female was appointed to Director of Staff Development - the first Black female manager - due to affirmative action requirements. In less than a year on the job, this Black manager:

  - was accused of not being a team player.
  - had her operational budget reduced from $10,000 to $1,000.
  - had staffing levels reduced from 11 to 4 and was required to accomplish the same goals.
  - was relocated out of the mainstream of activities.

In frustration, this Black manager resigned citing the inability of the organization to value differences while perpetrating an atmosphere of hostility; and harassment of a Black female through budgetary and staffing reductions.

B. **Black Male Manager**

Worked in Quality Assurance and was accused of unprofessional conduct with a patient or former patient. He filed an AA/EEO and MCAD complaint. It has been reported that he obtained damages in the amount of $60,000, and subsequently resigned for fear of retribution.

C.   <u>Hispanic Male Manager</u>

Worked at this psychiatric facility for 15 years. Recently White Managers were upgraded/promoted in the same job grade. This Hispanic Manager applied for an upgrade, as he met and exceeded the minimum requirements for the upgrade, and was denied. He has filed an AA/EEO and MCAD complaint, which is pending.

D.   <u>Asian Male Clinician</u>

Asian American clinician applied for promotion to a senior position and was not even called for an interview. He has pursued this issue with AA/EEO and the outcome is pending. This employee believed that he met the minimum requirements for the interview process and wonders whether slogans such as "minorities and women are encouraged to apply" and "EEO/AA employer" are really enforced when it comes to recruitment and career development for minorities.

Analysis of Multiculturalism

While Title VII and similar anti-discrimination laws have done much to make employee selection less a matter of hiring in one's own image and more a matter of true suitability and potential, the same cannot be said to apply to professional and promotional opportunities, as seen from the workforce analysis and case studies. There appears to be a noted tendency among managers in this psychiatric facility to discriminate in two important areas: promotional opportunity and professional challenge. It has been noted that while minority workers occupy more entry level jobs of low job grade, they are not getting an equal shake when it comes to promotional opportunities. The fact that there are only 2 minorities among a sample of 76 supervisors (with a percentage of 2.63) bespeakes this dismal picture of adverse impact. Whereas promotional opportunity is an area that can be addressed by policy implementation, creating opportunities for professional challenge is an ongoing effort. Managerial ability in this area is critical to keeping the best of workers; no challenge equals no motivation equals no commitment - equals departure. At one end is flat-out discrimination: the worker is not given the deserved opportunity or the worker's authority and span of control is diminished because of skin color or sex. At the other end, the minority is given a challenge but is monitored closely, thereby eroding the employee's self-esteem, while the Caucasian is given a task and allowed to pursue it to a successful conclusion independently, hardly equal treatment.

Conclusions and Recommendations

The following checklist has been used to ascertain an organization's problems with multiculturalism/cultural diversity:

1) Low acceptance rate of promotional opportunities by members of a specific cultural group

2) Reward system linked to values of the dominant culture

3) Career paths are not open to all cultural groups

4) Frequent unresolved clashes between cultures

5) High turnover among members of a specific cultural group

Checking any of the above indicates that an organization has a problem with cultural diversity. An examination of this psychiatric facility against the above criteria indicates a major problem with cultural diversity. Further substantiation is obtained from the workforce analysis and case studies which show a dismal lack of promotional opportunity and professional challenge for minorities.

Managing diversity does not mean controlling or containing diversity by forcing minorities, who speak for their rights and file AA/EEO and MCAD complaints, to leave their jobs as indicated in two of the case studies. It means enabling every member of a workforce to perform to his/her full potential. The essential challenge to a public psychiatric facility in managing cultural diversity is learning how to allow for differences and not overtly, covertly or tacitly force all employees to be the same. Differences are to be respected rather than seeking to smooth them out (or getting rid of them). This public psychiatric facility has to become multicultural rather than culture blind with equal promotional and professional opportunity for minorities. Successfully managing a culturally diverse workforce requires a new breed of manager who must be able to resolve conflicts; promote equality and fairness; alleviate bitterness among members of ethnic groups, and adverse impact.

Multiculturalism and cultural diversity are not social issues, but a business necessity. Managers and Supervisors must accept employees' cultural differences and learn to structure jobs so as to accommodate and take advantage of those differences. (Then maybe $60,000 MCAD suits would not be paid out because differences are rejected). There have to be more promotional and professional opportunities for minorities, more minorities in supervisory positions and management positions and minorities on the executive staff. Janet Reno and the Clinton Administration have made equal opportunity for minorities a priority and intend to prosecute violators of Title VII. It is time for all organizations to comply and focus on:

- Quality not appearance
- Ethics not rules
- Knowledge not achievement
- Integrity not domination

Diversity is a sound that must be heard.

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About the Authors:

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CASA PRIMAVERA: A response to the needs of Latinos with prolonged mental illness for psychosocial rehabilitation

by

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INTRODUCTION

This paper will review the development and implementation of a unique program for the psychosocial rehabilitation of inner city Latinos with long term mental illness. "Casa Primavera" resembles a psychosocial rehabilitation clubhouse but has been modified to reflect the cultural strengths and traditions across the spectrum of Latino experience. These include the centrality of family and interpersonal relationships for mental health, an emphasis on "personalismo" as a responsibility for each member toward the others, a belief in work as a contribution toward the collective well-being rather than simply as a personal achievement or indication of self worth, the importance of "respeto" in relationships among members, and an emphasis on music, celebration and ritual as restorative activities in daily life.

The authors are three senior clinicians/administrators who have a variety of experiences related to the psychosocial complexities of mental illness as it relates to ethnicity/race, social-economic status, gender, sexual preference, trauma, and dislocation. As a result of these experiences, we have come to realize the importance of psychosocial rehabilitation as an essential ingredient for the well-being of persons with prolonged mental illness. The rehabilitation philosophy emphasizes work and productivity as restorative for mental health and is a vehicle for self-efficacy and increased ego strength. Another guiding principle in psychosocial rehabilitation, especially in the Fountain House model, emphasizes the concept of community empowerment and collective responsibility for mental health among the mentally ill. We realized the importance of these rehabilitation principles which when integrated with aspects of Latino culture would allow us to create a unique program for rehabilitation. Unlike some proponents of psychosocial rehabilitation who advocate community empowerment as the only effective treatment modality, this rehabilitation model does not preclude and indeed relies upon other types of

treatment interventions such as the use of psychotropic medications, case-management, inpatient hospitalization, psychotherapy, and primary medical care. We believe that the nature and complexity of mental illness is a long term and cyclical phenomenon that demands a multi-faceted approach to treatment.

Because all communities, including communities which may be identified as Latino, differ socially, politically, and economically, the notion of exporting a model of rehabilitation is problematic (Bachrach, 1988). As previously noted, a key influence for the development of Casa Primavera has been the Fountain House Program which communicates four messages to participants: 1) each participant is a member rather than a client or patient, 2) members' presence in the club is needed on a daily basis, 3) individuals are wanted as members because of the contributions they make to the program, and 4) without member cooperation the clubhouse would collapse. The Fountain House model is guided by the belief that work and the opportunity to achieve is a deeply healing and restorative force in the life of a human being. Fountain House is also unique in that it involves a horizontal ordering of roles where the club members actively participate in the development of their own treatment plans, and in all decisions affecting their lives. We have found, however, that the complexities of mental illness sometimes require the leadership of professional staff in order to facilitate member empowerment and rehabilitation.

OVERVIEW OF CASA PRIMAVERA

Casa Primavera is a rehabilitation clubhouse program for Latino adults ages 19 to 60. The program includes components where members develop their basic living, interpersonal, and prevocational skills. Our program is unique in that it is culturally, geographically, linguistically and economically accessible to mentally ill Latinos residing in the inner city of Boston.

Traditionally, Latinos with severe and long-term mental disabilities have not optimally profited from existing services due to language and cultural barriers. This Department of Mental Health sponsored club is a program of La Alianza Hispana, Inc., a large Latino multi-service agency with links and an array of services germain to the needs of the mentally ill. In effect, this is a one stop shopping approach to mental health care which respects the autonomy of Casa Primavera and its members and provides quick and easy access through La Alianza Hispana or other DMH facilities to services such as medication, housing and inpatient care. Because La Alianza Hispana offers an array of services to the Latino community which are not predicated on having a mental illness, members of the club are able to be integrated into such activities as English as a second language, literacy training, computer skills, elder social/recreation and day programs, youth services and participate in agency-wide social and cultural activities. This normalization experience we believe is key for rehabilitating the mentally ill and for strengthening ties with the community as a whole. While we understand the philosophy of separateness and self reliance inherent in some therapeutic communities, our

experience and feedback from Latinos with mental illness is that most want and need to feel part of their culture and families. A key aspect of Casa Primavera is that members have initiated the integration of family members into some aspects of the functioning of the program.

Activities are carried out with staff guidance but with the emphasis on promoting horizontal ordering of roles between members and staff. Simply stated, club and staff member work side by side, with the staff using their best judgement as to when to encourage more activity or let things be for a while - primarily acting as energizers and social facilitators except in special circumstances and emergencies.

Promotion of Friendship/Companionship Opportunities

This is achieved through a series of activities intended to foster cooperative behavior and social interaction. These activities are ethnic dances, celebrating different ethnic holidays within the various Hispanic groups such as Mother's day, Independence Day, Dia de la Raza, Dia del Arbol, Dia del Trabajador, Dia de los Santos, etc., collecting a record library of ethnic music, a video library for "cineterapia", poetry; creating a recipe book of various Latino foods, culturally syntonic games such as dominoes, and celebrating birthdays. Reflective group discussions are elicited through these activities. For example, using Acosta Nodal's (1977) model of movie debate for group therapy, the members view movies or videos of soap operas to refer to emotionally significant scenes from the movies. It is used for therapeutic insight development and for mental health education and preventive education. It also serves for language development. Existing films depicting family crises, marital conflict, child-rearing, social issues, AIDS, drug-abuse, sexual abuse, the plight and success of formerly hospitalized members, etc., are presented. Some of those films already have been created by the National Mental Health Group, in collaboration with the Cuban Institute for Art and Cinematographic Industries (camayd-Freixas; Uriarte, 1980), others are developed through the program by taping current events, and /or films shown on television. These films lead to awareness education, discussion of different perspectives, commonalities, recognition of feeling states, recognition of acceptable social behaviors, as well as self-defeating behaviors. Similarly, listening to music and poetry reach members at the emotional level, increase the verbalization of feeling experiences which are processed at a cognitive level, promoting mastery over their personal issues and problem solving techniques. Whenever possible, family members are included in some of these activities since extended family among Latinos is crucial to the functioning of the individual.

Planned recreational and social activities promote decision making skills, planning leadership and problem-solving techniques, daily living skills, encourage mutual support and provide the vehicle by which lasting friendships can be formed. For example, softball teams have been formed and developed into involvement in competition with other community teams. Involvement in sports has increased self-discipline and teamwork experience. Trophies and awards are displayed proudly

by members. This human contact and sense of belonging is a crucial principle for rehabilitation. Furthermore, it is important to note that all these activities are consistent with the philosophy of the program which has a strong belief that the individual is an active agent into his own transformation. Placing the control within the members is crucial particularly since their historical, personal, and socio-political experiences often have been perceived as external to them.

Casa Primavera's main objective is to provide a caring environment which allows each member the opportunity to learn and pursue individual goals while learning to reach out and be responsive toward each other's needs in a supportive, culturally sensitive, productive and encouraging atmosphere. All members contribute their skills to the maintenance of the Club. The staff works along with the members to create and maintain the program, with staff often being the energizers, activators and role models.

All of the activities in the Clubhouse are voluntary, but are seen as necessary to keep the club functioning. Members contribute through their daily participation, ensuring a program which is responsive to their needs. The staff, while working alongside the members in the club, help them evaluate their life skills. The clubhouse is the base for all members and staff activities and constitutes a supportive community through which members can identify their strengths and interests. This caring environment allows each member to pursue their individual goals, while learning to reach out and to help members participate in efforts to reach other members. Members also participate in goal oriented planning groups to help them develop a course and a purpose for future growth.

ASSISTING BLACK STUDENTS AT WHITE COLLEGES: TOWARDS A NEW MODEL OF EFFECTIVE INTERVENTION

Howard P. Ramseur, Ph.D.

There were 515,382 Black undergraduates at predominantly White four year colleges in Fall, 1990; they made up 72% of all Black students at four year colleges in the United States at that time. A review of the social science research literature shows that the situation of Black students at these colleges is often academically difficult, socially stressful, and for some, grim and filled with failure. In order to more effectively assist these students, this paper proposes moving away from reliance on the traditional approach, based on the counseling center and support office, to one that stresses early intervention, intervening where students live and work, and a reliance on continuing research and evaluation of the effectiveness of our efforts.

ASSISTING BLACK STUDENTS AT WHITE COLLEGES; TOWARDS A NEW MODEL OF EFFECTIVE INTERVENTION

Howard P. Ramseur, Ph.D.

There were 515,382 Black undergraduates at four year predominantly White colleges in Fall, 1990; they were 72% of all Black students at four year colleges in the United States at that time (U.S. Dept. of Education, 1992). This paper will examine their academic performance and psychosocial issues through a brief review and assessment of relevant social science research, and will then turn to a discussion of its implications for more effective treatment and environmental intervention. This paper draws on research literature, as well as the author's clinical experience at a university health service and observations of the climate at White colleges.

Perhaps the most comprehensive study of Black college students at four year colleges was done by Fleming (1984) who studied 2600 Black students at 15 colleges of widely different types and locations. Her focus was on the differences in the experience of Black students at predominantly Black or predominantly White colleges. Her assessment was that Black students fared better, intellectually, personally, and socially, at Black colleges than they did at White ones. In fact, she found White colleges were particularly poor at assisting the academic/intellectual development of Black students; in spite of having better facilities, faculty salaries, etc. Little positive contact with faculty, social isolation, alienation from campus life, and a sense of "institutional abandonment" were other findings across White campuses.

Fleming found White colleges a particularly grim environment for Black men. In fact, by senior year many of these men, who had typically entered with positive self esteem, high energy, and were academically competitive had turned away from academic pursuits, in what might be described as depressive withdrawal, and turned to extra-curricular activities for "tension release." While they gained in social/political skills and self-assertion, they showed no intellectual growth and poor grades. She describes Black women as in an equally painful situation, but turning from their isolation and frustrated social lives to academic work and faring better therefore than Black men.

Fleming (1984) argues that the college interpersonal climate is at the core of the differences in academic functioning of Black students at the two different types of schools. Fleming sees students at White colleges as lacking a "supportive community," a major positive factor at Black colleges. A supportive community consists of: social connectedness - the possibility of a friendship network of peers and role models; the opportunity to fully participate in the life of the campus - to have an impact on the environment and to be recognized; and a sense of progress and

success in academic pursuits - an evolving sense of accomplishment. She also notes that some attachment to faculty seems to help sustain academic motivation for Black students, and that low cognitive growth seemed linked to poor relations to faculty and few adult role models on campus.

While Fleming (1984) gives the most comprehensive look at Black students, a number of studies have focused on specific areas that will be reviewed: academic performance, social life with Black and White peers, racial incidents and climate, cultural adjustment, developmental issues, the characteristics of "successful" students, and mental health issues.

There is a voluminous literature on Black students and academic performance, but the general findings are clear: Black students have significantly lower grade point averages than their White peers, progress more slowly, and persist (stay in school) at a substantially lower rate than do their White peers. Black men are substantially lower on all these indices than Black women, and make up 40% or less of Black students (all other racial/ethnic groups have a 50/50% sex ratio). Allen (1988) in a study of Black students at the University of Michigan system found that 35% of all academic dropouts had occurred by the end of freshman year, and 70% had occurred by the end of sophomore year (versus 53% of non-academically related dropouts). Interestingly, Black student social and academic background characteristics are not as significant as predictors of academic performance as are "non-cognitive" variables. Things like, aspects of self-concept, coping abilities, social supports, and assessment of racial climate at the university.

Advisors that were perfunctory, "cold," had little information, or had low expectations of Black students, or who were openly racist or sexist were mentioned in a number of studies as difficulties by Black students. Lack of contact with faculty members was another frequently cited problem. Students also described being the only Black student in class and being asked to present the "Black" viewpoint. Professors or TAs expressing low or negative expectations of their academic ability, and a general lack of interest and involvement with them by professors, was reported by Black students, along with reports of a number of blatantly racist incidents involving faculty. One study, The Racial Climate at M.I.T. (1986), noted that 40% of the positive incidents with faculty mentioned by Black alumni were provided by Black faculty members who were less than 1% of the total faculty.

Contact with White peers is described as equally problematic by many students. They describe White students as "colder" than those they went to integrated high schools with and less open to friendships. Dorm life and culture is described as oriented to the social and cultural needs of the White majority with Black student views and issues largely ignored. Racial incidents involving White students are also frequently cited; as are incidents with campus police, often involving Black male students. (See Feagin, 1992.)

Many Black students leave integrated dormitory setting as soon as possible, and create all-Black social worlds and study groups for themselves. One college has an all Black male dorm unit called "Chocolate City," for example, where students center their social and study lives. A small, tight-knit Black community presents other stressors, however. A restricted social universe can present problems for finding friends, and lack of choices for dating. Some students speak of criticism and ostracism if they go outside the group for friends or dates. At one college, Black men who pledge "White" fraternities are considered "lost to the race" and largely ostracized.

Problems or stressors involving what Stikes (1984), in a review of case studies, calls "cultural adjustment" arise as well. He states that regularly admitted Black students take a year to make a successful cultural adjustment to White colleges, while "special admit" students take two years. The cultural issues that he describes as difficult are: time orientation, language differences, informal, casual way of relating versus the formal style of a White university, SES based perspectives on education's value, learning style, comfort seeking help, dating/sex norms, and difficulties with money management and financial aid. Stikes sees the areas as inter-related and inter-acting. He also states that students tend either to display a coping/problem-solving orientation or one focused on maintaining self-esteem and avoiding anxiety (e.g., avoiding an exam or more study).

Stikes (1984), in one of the relatively few studies that directly addresses developmental issues, also notes that all developmental tasks for Black students are affected by race. Branch-Simpson (1984) looked at the developmental status of Black OSU seniors and found a number of gender differences, and departures from classic developmental models based on White students. Continued inter-relatedness with family, the large importance of religion and religiosity, greater importance of emotional intimacy for women than men, and more uncertainty about career direction by senior year for women were her major finding for these students. Racial identity was also a key developmental area cited by a number of authors--what does it mean to be a Black man or women in 1993, how do I fit into the college and larger Black community, what contribution can I make to the community (versus myself), were questions wrestled with, or avoided, by students, and cited in the literature (see Sedlacek, 1987 for a review).

The research literature largely defines "successful" Black students in terms of academic performance--grades, academic progression, or retention, with less attention given to other aspects of psychosocial adjustment. Kraft (1991) interviewed 43 Black students who said academic success at a White college came from "discipline" and "social support". A "disciplined" student is a student who schedules and uses study time well (vs. socializing), has appropriate time allocated to tasks, assesses realistically the importance of paper/test to course and course to career, puts in hard work and time on task. "Social support" came from faculty, fellow students, parents, and fellow church members. Women emphasized social support, especially relations with faculty, more than men. Men stressed overcoming

academic difficulties as a matter of using personal strengths to solve problems, faith in one's ability, and hard work and ambition to succeed over obstacles (alone).

Mow and Nettles (1990), in a literature review, point out that the factors that predict high Black student GPA differ somewhat by type of university--large public research, regional public, prestigious private, etc. Generally high satisfaction with the university, high academic integration (relations with faculty), low feeling of discrimination, low financial need, low number of interfering problems, positive study habits, on campus residence, and degree aspirations were all more significant predictors than background characteristics for GPA. Tracey & Sedlacek (1984) tested the ability of the Non-Cognitive Questionnaire (NCQ) to predict the academic performance and retention of Black students. Based on earlier work, the instrument assesses seven 'non-cognitive' variables (e.g., positive self-concept) and was found to have good predictive validity for college grades and persistence for Black students.

In terms of characteristics that led to low achievement, Bean and Hull (1984) found that high alienation, and low sense of belonging at college, and low institutional commitment were linked to low grades. Stikes (1984) found that low achievers had high personal/social stress, no regular routine, delayed work until the last minute, and high denial of personal responsibility for their behavior, avoided helpers, and stated that failure was regrettable, but inevitable, (See Chart 1.)

Research that looks directly at the psychological health of Black students is sparse. However, one questionnaire study by Nottingham, Rosen, & Parks (1992) compared Black students at a Black and another predominantly White Texas college on measures of psychological health and stress. They found no difference between the two groups in their scores on measures of depression, hopelessness, suicidal ideation, and self esteem. Both groups were relatively free of emotional distress. Students at the White college reported more feelings of social estrangement/loneliness, having less adequate information on African-American subjects, fewer opportunities to date, and more experiences with racism.

A number of studies discuss treatment issues and Black students. One representative study by Clay (1992) points out that Black students tend to use informal networks of friends, family, and church groups for support and help with emotional/social difficulties rather than university counseling centers or psychiatry services. While they present with the full range of concerns, the most common presenting complaints of Black female students were: academic problems, marginality and adjustment to the college environment, family and financial problems, difficulties with racial identity, and problems finding a positive, intimate relationship. Similar areas were cited in other studies of a broader range of students (see, for example, Gibbs, 1975).

My own observations parallel research findings: a substantial proportion of Black students at White colleges find them highly stressful, academically difficult,

socially isolated and frustrating places to be for four years. Many students drop out and never graduate; and of those that graduate, a significant number leave with their self-esteem and sense of academic competence lower than when they entered. Many Black students develop academic problems early on; in my experience freshman year, especially first term, is a crucial time for establishing academic patterns and problems. In addition, when Black students run into academic difficulty, many either withdraw into themselves or avoid addressing the issue until the last minute and therefore don't make good use of available resources. Positive contact with faculty also seems to be a key factor in academic success.

A major issue that this literature points to, but doesn't explore, is the with-in group variation of Black students at White colleges. For example, there seem to be different patterns of coping with academic difficulties and different results, on average, between Black male and female students. In addition, some Black students are academically 'successful' at these colleges, many survive, while others drop-out. What are the central factors leading to these outcomes? Many research studies simply compare Black and White students and don't examine patterns among Black students which might point to the factors that are central in explaining their situation. In addition, there is an absence of the actual perspective of Black students in the literature; questionnaire based studies that produce statistical association between specific variables, or regression equations or factor analyses are the norm (with a few interview studies). These studies typically end up with a list of variables or issues. Case studies, or even focus groups, that give Black students a voice, or that put single variables or associations in context are relatively rare.

Much of this research also ignores the reality that Black students are passing through late adolescence, an important developmental period for racial identity and social/sexual identity development. What is the impact of struggling with these issues in a stressful, racially tense or hostile environment, where a student has few Black peers or Black adult mentors? No model, and few good hypotheses exist in this literature. In my experience, while many Black students successfully cope with these issues, others put their development 'on hold' and almost consciously avoid struggling with these issues while in college.

Although little noted in the research literature, some Black students do well and seem to find their four years at a White college productive and enjoyable. Who they are and their characteristics are worth exploring. My own observations of mental health and healthy functioning among Black students lead me to see certain characteristics as central: resilience in the face of stress, realism about the social and academic environment (including its racism) and its demands, planfulness, a sense of competence, self-respect and respect for other Blacks, and finally an ability to be inter-dependent both in personal relationships and group activities.

In summary, the major issues facing Black students are: academic problems-- problems with grades, retention, and feeling competent and ready for the career world, feelings of alienation and social isolation from faculty and peers on campus,

cultural adjustment issues, struggles with racial identity and other psychosocial development issues (that some put on 'hold'), and coping with campus racial incidents.

How do mental health providers help Black students cope with the demands of White college campuses and achieve healthy functioning, however defined. Most colleges now rely on a counseling center or mental health service that offers individual or group counseling on site, and a minority support office that offers tutoring, some personal counseling with an administrator, and the occasional lecture series. While useful, this approach only assists some of those who come in and make use of these formal sources of help. Research cited earlier, and my own experience, points out that many Black students won't use these resources or finally approach them so late in their difficulties as to render them less useful.

Based on the research reviewed here and my experience, we need a different approach to assisting Black students' psychosocial and academic adjustment. An approach that stresses preventive and early intervention, that intervenes in the environment where students live and work, that is based on continuing research and clinical knowledge, and that rigorously evaluates the effectiveness of interventions.

If we focus on the area identified as difficult for Black students and important in Fleming's notion of "supportive community" we can sketch out how such a model might look in practice. For example, the traditional counseling center could build on its current practices by having a diverse staff, extensive in-service training about the situation of students of color, bring in 'experts' to consult on individual cases and institutional incidents, and hold meetings or panels where Black students discuss their experiences at the college. In addition, more active intervention in the college community would be useful. One useful model is that of "Common Ground," a bi-weekly lecture/discussion meeting offered over dinner, often in the dorms, for students of color by the deans and counselors of a Boston-area college. Open to faculty, staff, and administrators as well as students, the focus is on issues like racial identity, male-female relationships, and politics. Presentations are given by care-givers at the college, and returning alumni, along with others. Informal discussion of student reactions and experience is the focus. The format allows students to informally meet faculty and care-givers and some students are able to integrate them into their informal support network.

Many studies, including the Racial Climate at MIT (1986) cite the importance of relationships with faculty for the academic performance and sense of belonging to the institution for Black students. Facilitating Black students' comfortable and positive interactions with faculty (and TAs) is therefore crucial. Pairing Black students with faculty advisors who have good people skills, have had training to make them sensitive to the issues facing Black students, who are ready to intervene early and able to face some initial resistance and reluctance ought to be useful. Also, Black freshmen advisors could be sent test and other grade reports soon after they

are given, with the student's permission, as a sort of early warning system to facilitate early intervention. Another possible model is MIT's UROP program, where undergraduates do research work with professors, for pay or course credit, and get first hand experience of academic research and often a mentoring relationship.

Seeing the university as non-discriminatory is also linked to Black student adjustment in a number of studies. Therefore, it is important to make sure the university has a clear non-discrimination policy that is publicly announced, clear procedures for handling racial incidents that are also known and rigorously followed, and guidelines for campus police as well. A curriculum that includes the history and culture of Black students, and other students of color, that has ethnic studies courses, and a social and extra-curricular life where Black students feel able to comfortably participate would be another key component.

While almost every White college has academic and social support programs to address the needs of Black students, few have been rigorously evaluated as to whether they are meeting their goals overall, or as to which aspects of the programs are successful and which aren't. There also seems to be relatively little information sharing across campuses about programs and their effectiveness. Both issues need to be addressed. Effective intervention also needs to be based on valid knowledge of the situation and development of Black students--therefore, research on positive coping styles, informal help-seeking behavior and networks, 'expectable' stressors and developmental difficulties needs to be sponsored by colleges.

The situation of Black students at four year, predominantly White colleges is often academically difficult, socially stressful, and for some, grim and filled with failure. This paper has proposed moving away from reliance on the counseling center and support office based approach to assisting Black students to one that stresses early intervention, intervening where students live and work, and a reliance on continuing research and evaluation of the effectiveness of our efforts. These students deserve no less.

ACADEMICALLY 'SUCCESSFUL' BLACK STUDENTS

(CHART 1)

Kraft (1991)

Disciplined Student
schedules and uses study
    time well
time allocated to task
realistic assessment of
    exams and courses
high time on task
hard worker
Social Support
peers
faculty
parents
church

Mow and Nettles (1991)

high satisfaction with college
high academic integration
low feeling of campus
    discrimination
low financial need
    low number of interfering
    problems
positive study habits
on campus residence
high degree aspirations

Tracey & Sedlacek (1984)

positive self-concept
realistic self-appraisal
understanding and ability
    to deal with racism
long-term goal focus
strong support person
    available
successful leadership
    experience
community service

Stikes (1984) - Low Achiever

high personal/social stress
no regular routine
delay work until last minute
high denial of personal
    responsible. for behavior
avoid helpers
failure regrettable, but
    inevitable

Bean & Hull (1984) - Low Achiever

high alienation
low sense of belonging
low institutional commitment

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Minorities and the Psychiatric Rehabilitation Approach: How Can It Work?

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Introduction

The rate at which the minority population of the U.S. is changing is astonishing. These effects will be felt throughout all aspects of American life. Recently, the Census Bureau's figures suggest the following: since 1980 the proportion of Americans identifying themselves as White declined to 80.3%. The 1990 census data indicate the African American population stands at 30 million, an increase of more than 13% since 1980; 7.3 million Asians, an increase of almost 38%; and 22 million for Hispanics, an increase of 53%. Some estimate that by the year 2000, 30% of Americans will be of a racial minority (Dunn, 1992). Therefore, vocational rehabilitation and mental health programs must be willing to accept the challenges presented by the changing demographics of our society.

Using 1981 U.S. Census data, Walker (1988) stated that there were 22.6 million Americans with a significant disability. Of that number, 4.6 million were non-White. Some studies show that African Americans were underserved with the state/federal vocational rehabilitation system (Atkins and Wright, 1980). While studies for other minority groups are grossly lacking, anecdotal evidence and studies of other human services delivery systems (Sue and McKinney, 1975) imply the majority population have been far better served than minorities.

The 1989 annual report of the Rehabilitation Services Administration to the President and Congress suggests lower participation by minorities in rehabilitation than their numbers in the general population. Of the approximately 217,767 closures in which race was reported, 38,565 (17.7%0 involved African Americans, 1,209 (0.6%) involved Native Americans, 2,847 (1.3%) involved Asian Americans, and 16,374 (7.5%) involved people of Hispanic origin. These figures represent race and types of disability groups. In fact, figures relating to minorities with psychiatric disabilities are scarce. For example, Anthony (1991), states that 2.4 million people in the U.S. have a severe psychiatric disability. This figure reflects the general population and does not specify how many of these are minorities.

Programs designed to address the vocational needs of minorities with psychiatric disabilities are seriously lacking. Many minorities have been locked out of vocational rehabilitation systems. For example, Atkins and Wright (1980) reported that African Americans were more likely to be screened out of vocational rehabilitation that were White clients. One reason given by vocational rehabilitation counselors for nonacceptance was "failure to cooperate." It is

reasonable to expect that we must work within the value system of the clientele we are helping. For example, when programs work with Hispanics, Smart and Smart, 1991 suggest the inclusion of the family. therefore, it is absolutely critical for programs working with minorities to focus on building a successful relationship between the counselor and the client.

In summary, minorities face several barriers when attempting to access the vocational rehabilitation system. These barriers include attitudes of professionals towards minorities, insensitivity to cultural differences, and the lack of skills on behalf of practitioners to help minorities. Flexibility appears to be a key factor when working with minorities who have psychiatric disabilities.

Description of Psychiatric Vocational Rehabilitation Approach

One approach that holds promise for this population is the Psychiatric Rehabilitation Approach (Anthony, 1979). In this approach, success is measured by the individual and the focus is on coming from the individual's frame of reference. The potential success of the Psychiatric Rehabilitation Approach for minorities is that it focuses on the rehabilitation process and not the racial and cultural background of the individual. The goal of this paper is to demonstrate how the mission of the Psychiatric Rehabilitation Approach can benefit and empower minorities who have psychiatric disabilities.

Recently, the **Center for Psychiatric Rehabilitation** was awarded a National Institute of Mental Health research grant from the Massachusetts Department of Mental Health in association with the Massachusetts Rehabilitation Commission. The project is an experimental study designed to evaluate the effectiveness of the Psychiatric Vocational Rehabilitation approach, known as PVS. Special emphasis of the project was to include minorities as subjects.

The Psychiatric Rehabilitation Approach (Anthony, 1979), is the theoretical framework of the Boston University Vocational Rehabilitation approach. The mission of psychiatric rehabilitation is to help persons with psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention (Anthony, 1979). The major methods by which this mission is accomplished involves effectively and/or developing the resources needed to support the client's present level of functioning (Anthony et al., 1983). The values reflected in this mission statement are;

FUNCTIONING: A focus on the performance of everyday activities.

SUCCESS: A focus on meeting the requirements of other people in
the client's world.

SATISFACTION: A focus on the client's feelings of happiness.

ENVIRONMENTAL SPECIFICITY: A focus on the "real world" context of where a person lives, learns, or works.

CHOICE: A focus on self-determined goals.

OUTCOME ORIENTATION: A focus on evaluating rehabilitation in terms of the impact of client outcomes.

SUPPORT: A focus on providing assistance for as long as it is needed and wanted.

GROWTH POTENTIAL: A focus on the improvement in the client's functioning and status.

It has been our experience that, when given the opportunity, persons with psychiatric disabilities can be engaged in setting their own goals. A major barrier for minorities with psychiatric disabilities in our society is that they are often in a subordinate position, and the opportunities to set and reach goals are practically non-existent. The application of this model provides minorities who have psychiatric disabilities with the opportunity to make their own choices.

Anthony and Jansen (1984) indicate that vocational outcomes of persons with psychiatric disabilities are correlated with client skills, supports and employment history. In response to those findings, the "Choose-Get-Keep" approach to vocational services for people with psychiatric disabilities was first described by Anthony, Howell, and Danley (1984). The concept was later applied to supported employment by Danley and Anthony (1987). The program model for Psychiatric Vocational Rehabilitation follows the Choose, Get, and Keep approach.

PHASE I -   **CAMPUS INSTRUCTION** (Months 1-6)
* <u>Program Focus</u>: Vocational planning (not long & short range)
* <u>Primary Practitioner Activities:</u> Large group instruction (12 people per group), relationship building, and network assessment and development.
* <u>Primary Setting</u>: College classroom, and staff offices.

PHASE II -   **COMMUNITY TRANSITION** (Months 7-12)
* <u>Program Focus</u>: Selecting and securing access to specific vocational environments.
* <u>Primary Practitioner Activities</u>: Small group instruction and support (3-6 people per group), marketing the client and the program, individual assessment and instruction, and resource development.

*   <u>Primary Setting</u>: Staff offices, college classroom and community settings.

PHASE III - **COMMUNITY STABILIZATION** (Months 13-18)
*   <u>Program Focus:</u> Identifying and developing the unique set of skills and supports required for success and satisfaction in vocational environments.
*   <u>Primary Practitioner Activities</u>: Individual instruction and support, small group support, resource development, and community consultation.
*   <u>Primary Setting</u>: Community settings, and staff offices.

Current Program Status

To date there are 27 participants assigned to the experimental group which is the Boston University Psychiatric Vocational Rehabilitation (PVR). There are 13 minority students, or 48% of the group. There are two PVR classes in session. One class is within one month of completion of the first phase of the program, and the other class is starting the first phase. Of the group nearing completion, 100% of the minorities have made choices concerning their next environment. Of those, 90% chose work and 10% chose a learning environment.

Benefits of the Psychiatric Rehabilitation Mission

In order to closely examine the benefits of psychiatric rehabilitation for minorities, it is important to revisit the mission statement. As stated earlier, the mission of Psychiatric Rehabilitation is to help persons with psychiatric disabilities increase their <u>functioning</u> so that they are <u>successful and satisfied</u> in the <u>environments</u> of their <u>choice</u> with <u>the least amount of ongoing professional intervention</u> (Anthony, 1979).

Functioning

What this implies is that the program is focusing on improving performance of everyday activities, rather than on reducing symptoms. This benefits minorities because they are assessed on how they function within the present environment rather than according to the idiosyncrasies of the counselor. For example, if a student is being disruptive in class, the teacher reminds the student of the requirements needed to participate in the class, rather than assuming it is a function of psychiatric symptoms. This approach gives the student the opportunity to control his own behavior.

Success

Success in rehabilitation is defined in terms of meeting the demands of the environment. The benefit to minorities is that they define the environment in

which they want to function. Choosing what success means is related to their own performance in relation to the environment. One student defines her success as being able to function within a university setting. She wants to be seen as a student, and consequently changed her style of dress to reflect the dress code of other students within the university.

Satisfaction

Client satisfaction is critical. If clients are not happy in the environment, they will not want to stay. Therefore, the power of deciding what they like versus having someone define it for them is important for minorities. They have encountered many failures with the vocational rehabilitation system partially because they have not been asked or allowed to choose what would make them happy. For many of the students in our class, this is the first time that they have gotten to define what satisfaction means to them.

Environment of Choice

Having the power to choose where they want to live, learn, work or socialize will empower the student. Traditionally, Whites have been able to practice racism because they have had the economic, social, and political power over minorities (Smith&Bond, 1990). The impact has been a tremendous lack of opportunity for minorities to define their values, and make choices. Everyone who is in the class is there because they want to be there.

Support

Within the program, we offered ongoing support as needed and wanted. Support can take the form of people, places, and things. This approach allows the client to define what support means to them. Ongoing support is typically provided by the program. However, this project is grant-funded and therefore time limited. With this in mind, during the last phase of the project, one of the activities is resource development to assist clients in identifying supports.

Conclusions

It is imperative that the barriers faced by minorities attempting to gain access to vocational rehabilitation services be removed. Any approach used to help minorities has to be one that is built on exploring and understanding their needs and sensitive to their cultural differences. It has to be driven by the needs of the client, as opposed to the needs of the system. Client-driven approaches are one of the few approaches that can be successful in helping minorities because they demand that the rehabilitation process comes from the client's frame of reference. If the focus is on the process, the attitudes of the counselor becomes less of a factor, which potentially allows minorities the opportunity to get the best vocational rehabilitation possible in order to be successful in their environment of choice.

Recommendations

1) In the mental health field, most trained counselors are White and middle class, but most clients are from varied racial and socioeconomic groups (Pederson, 1978). Therefore, there is a need for the counselor to become culturally aware, and be equipped with the necessary skills to engage the client in a mutual relationship, based on respect.

2) We must understand and respond to the changing demographics of our society. In order to adequately respond, a commitment must be made and funding allocated to the training of members of minority groups and training all professionals to work with minorities. This includes encouraging and training individuals who are bi-lingual to become counseling professionals.

3) As with most causes, adequate research is one of the first steps in addressing the issues. Therefore, the establishment of government funded research facilities that identify and document the issues facing minorities is essential.

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OUTPATIENT TREATMENT OF BLACK VETERAN SUBSTANCE ABUSERS

Lois Belle Sellers

PART I

This presentation will consider the impact of race on the treatment of Black substance abusers and the possibility of improvement in treatment outcome with heightened cultural sensitivity.

Substance abuse at a local medical center is conceptually defined as the continued use of addicting substances, including alcohol, in spite of the fact that the use of substances has resulted in problems for the user in his home, family, employment, and relationships with others. The heavy losses to the user and to those for whom he is responsible seem to have little or no influence in curtailing further use of the damaging substances. Substance abuse is a relapse disorder and recidivism is a common occurrence.

Abusers seeking treatment at the medical center are evaluated for admission into the Aftercare/Outpatient Program and a psychosocial history is attained. A part of the client's psychosocial history seeks information about his cultural background to ascertain whether his ethnicity will be an influencing factor in planning his treatment.

My foci in assessing clients for treatment has been to use the psychosocial history to ferret out the client's positive assets which may be used to increase the likelihood of treatment success. Successful treatment outcome is perceived at the Medical Center as abstinence for one year with effective coping behavior in controlling one's life, evidenced by improved mental and physical health, improved family and social function, and/or improved general life functioning.

The theoretical framework undergirding my treatment strategies relates to the helpless, hopeless, worthless feelings which have been said to characterize the substance abusers. Thus, vigil is maintained to promote self esteem and valuing of the client in all treatment efforts. The client is helped to feel empowered to select those choices which would be beneficial, or less harmful to him, and to use the coping skills that he has been taught. The client is helped to enlarge his vision of the realities in his life and the possibility of effecting desirable change.

PART II

Client A

Client A was a 27 year old, 40 percent service connected Black male, he was separated from his wife and was the father of a four year old son. He has been known to the medical center since 1987 and he became my client in 1989. The concerns noted were:

Medical/Physical/Psychological - Arthritis of left leg and shoulder; psychiatric treatment for depression; previous history of four suicide attempts at ages 9, 24, 25, and 26.

o   Family - Reared by his maternal grandparents, only child of his parents, later had half brothers and sisters; did not know father while growing up.

o   Academic - GED; attended a junior college; expressed a desire to return to college.

o   Economic - Unemployed; work therapy; later used his initiative to be employed at the medical center on the food line. Previous employment as a fork-lift driver and an accounting clerk.

o   Religious/Spiritual Life - Not part of present life; important to his family when he was growing up.

o   Military - Apparently not a problem for client; discharged honorably as an E-4 with a service connected disability. Client said he "fought to stay in the Army."

o   Substance use - Polysubstance abuser; using alcohol, Cannabis; preferring cocaine; denied I.V. use of heroin.

    -    Client began using alcohol and street drugs at age 12; first treatment at age 18; longest period of sobriety was 8 months at age 26. He said his substance use had caused him to lose money, to lose weight, and to lose his self esteem.

    -    Father sober from alcohol 8 years; Mother uses alcohol and cannabis.

o   Leisure/Social Life: AA; Fishing.

o   Strengths from client's view - Speaks well.

o   Weakness - "Gullible - not streetwise"; "good hearted."

The Inpatient Treatment Program described client as neat in appearance and friendly with peers and staff. It was recorded that he had inappropriate social behavior, lacked interpersonal communication skills, was constantly seeking attention, and seemed to lack motivation to change his leisure life style.

Aftercare treatment for Client A was unrewarding. Initially, I tried to encourage his stated interest in returning to college, provide teaching to reinforce his knowledge and the use of the "tools" for sobriety, and to avail him with a prescription for antabuse as he requested. Later, during a group session, client wept when referring to his grandmother and I then began, in the individual conferences to have client to talk about his dreams and his hurts. Client mentioned his girlfriend's associates who had education, money, position, etc., and he seemed to long to have these things too. He also said that when he was growing up, his cousins seemed to have a lot of fun time with their father and he wanted the same thing from his father. Another time, when client received recognition for a "no smoking" poster that he'd made, he asked the photographer to wait until he removed a long dangling earring he was wearing in one ear. When asked why he removed the earring, client said that he did not want his picture taken wearing an earring. Client A seemed somewhat depressed when he told me that his wife was living with a man. He said he did not want his son living in such a situation, apparently holding his wife to a higher standard then he used for himself.

Early in 1991, client was discharged from the Aftercare Treatment Program due to his sporadic involvement in the Program. He canceled appointments, would not go to the library to use materials set aside for his bibliotherapy, periodically ceased taking antabuse so he could drink, and often mentioned his relapses in the group sessions, adding that his counselor did not know. There was no evidence that Client A was committed to relapse prevention and recovery; he was clearly impersistent. Client A was pleasant, liked by fellow clients, and he seemed to use the Aftercare Program to foster his own agendas. A referral was made to the chaplain so client could continue discussing any needs he had without following the structure required in the Aftercare Treatment Program.

Client B

Client B is a 42 year old Black, 60 percent service connected, divorced male with two daughters. He is an Aftercare client and he has been known to the medical center since 1986. He became my client in 1991 and he is still in the Aftercare Program. the concerns noted were:

o   Medical/Physical/Psychological - Post Traumatic Stress Syndrome (PTSD); osteoarthritis; depression with four suicidal attempts.

o   Family - Fourth of 9 children; lived with paternal grandparents in Georgia until age 6, then rejoined parents when they were settled in Massachusetts.

- Mother died in 1983 with cancer; father died in January 1993 with lung cancer.

- No contact with family members, but relates to daughters and maintained contact with father until his death.

o Academic - GED; 45 college credits in Afro-American studies; desires to continue in college.

o Economic - Unemployed; work therapy; previously employed as a roofer and a software designer for computers.

o Religious/Spiritual Life - Atheist for 23 years ; family Southern Baptist.

o Military - Platoon Sergeant in charge of 46 men.

o Legal History - Criminal record; 12 years in prison.

o Cultural/Ethnicity - Stated "It's important to know your ethnic background"

o Substance Use - Neither parents used alcohol or drugs. Client's first use was at age 15; smoked opium at 18 years in Vietnam; first treatment at age 20; longest period of sobriety was 12 years while in prison.

o Strengths - Follow through with projects if not on drugs; good listener; machinery aptitude.

o Weakness - "Not much thought given to it." Client often has a guarded, cautious, intimidating mien.

When Client B first enrolled into the Aftercare Program, he said he had been around the Medical Center for sometime and no one had shown him the way to improve himself or reach any goals. He said if his life was to be in and out of the hospital, there was no point in living and he would just as well commit suicide now. I told client that he could help himself and began to ask about his goals. Client offered no specific goals, but seemed to want help in making things better for himself generally.

My treatment strategies for Client B were primarily to establish a therapeutic relationship with him. He was basically distrusting of others, angry about little slights, and bitter toward God about the Vietnam War. Ventilatory therapy, unconditional positive regard, and acknowledgement of his assets permit me to say today that I believe I have a solid relationship with Client B. His psychiatrist and I have collaborated, with client's knowledge and permission, and we work together for Client B's best interest.

A handout on Relationship Traps was distributed to the clients in the Aftercare Program. Client B seemed to really appreciate the handout and came back for other copies because he had given his copy away. Client B marked the traps on the handout that he wanted to discuss with me, and he began to see how he had contributed to some of his problematic relationships.

Client B left the Medical Center for a three month PTSD treatment program and since returning, he has had two relapses; he has lost two persons to whom he seemed close; he has had serious problems in his living situation.

At this writing, client is still in treatment; he seems very amenable to improving life for himself. He seems less distrusting but he still has a tendency to sabotage his efforts to "handle" any slights he perceives to his dignity.

PART III

Culture Sensitivity Screen

I have shared with you a brief description of Clients A & B and the treatments that they received. Looking through the culturally sensitive screen we can show how the treatment approaches may have been modified for a successful outcome. The culturally sensitive screen is a mental overlay which alerts the treatment provider to better understand what it may mean to the client to be Black in a racist society. The Black person experiences the impact of racism, discrimination, overt and covert devaluing from conception to death. This racist environment provides the matrix for the Black person to have a negative view of himself, a negative view of society, and a negative view of his future. It reinforces the hopeless, helpless, worthless feeling which usually typifies any substance abuser. The Black person may see the dominant group as its reference group and accept the dominant group's appraisal of his ethnic role as one of inferiority.

It is important to mention here that being a member of a minority group does not mean the same thing for every Black person. Each person operates within a context of many variables such as family, friends, associates, education, economic status, etc., and interpret and react to their status in different ways. Yet it would be a mistake to not acknowledge the matrix of racism and discrimination in this society.

Viewing Client A through the cultural screen, I see his noncompliance to treatment differently, although I do not believe I could have intervened effectively with him on an outpatient basis. I saw Client A's interest in the night life, "Cool Cat" behavior as evidence of his immaturity and interest in approximating a celebrity type life style since hair do, dress, etc. seemed important to him. Majors' and Billson's book "Cool Pose" enlarged my consideration that Client A's behavior may have been a survival strategy against indignities and inequities which he had

experienced. The wounds which seemed to be festering within him apparently were caused by comparing his lack of having a loving father about when his cousins seemed to do fun things with their father. This fragment of information was only revealed when client was encouraged to tell his story, his dreams, and his hurt. Missed treatment sessions, abbreviated sessions (due to client's late arrival or early departure), and/or relapses negated exploration or confirmation of the significance of the information he offered.

Client A had said religion was important to his family when growing up but not to him presently, however he reflected some essence of spirituality when he talked about the environment he wanted for his son and his interest in helping others. Since religion has been a positive variable for Blacks meeting life problems at its center, without the loss of their dignity, I referred Client A to the chaplain who was on our treatment team. I discharged Client A but he continued to see the chaplain until he was transferred to another hospital to have surgery on his leg. It is my belief that Client A will have better treatment outcome in the future if the wounds of his early years are explored and treated and his present "self-inflicted social wounds" are examined and treated under the scrutiny of coping strategies for a discriminating society. Ventilatory and bibliotherapy should be the major strategies for achieving this, however within an inpatient status to insure Client A's availability for treatment.

Client B is still in treatment with me and I believe the cultural sensitivity screen highlights every aspect of his being. He seems to mirror the negatives that he has experienced and to believe in explosive resolution of his problems if he deems it necessary. Previously I held a personal hypothesis that the knowledge of one's heritage could be an avenue for exchanging negative survival strategies for effective coping skills, however Client B has 45 college credits in Afro-American studies and he still hangs onto his hostilities and his "pay back list." Client B has said he wants his life to change. He is amenable to treatment, keeps his appointments, tries to follow directions and suggestions. He is high in self-efficacy and it is enhanced when he feels his dignity is respected. Therefore, it is my belief that his treatment plan should help him to focus on the positive qualities of the Black leaders he admires and may wish to emulate in some way. Client B says, without hesitation, that he is an atheist and permits no direct discussion of religion or spirituality in any way, yet he expresses strong feelings regarding what is right, what is wrong, the should and the shouldn't.

Client B seems to have unresolved grief from his mother's death in 1983, a death last year of a personnel at the Medical Center who treated him kindly, and from his father's death, January 1993. Culturally, it was not easy for client to talk about or show his grief, however I asked him, before his father's death, if he thought his recent relapses related to the death of the personnel he liked and he said it was "possibly so."

PART IV

Recommendations

It is humbling to make recommendations to the State Department of Mental Health. It is laudable that there is a Multi-Cultural Advisory Committee that can be instrumental in effecting positive directions for minorities.

President Clinton has asked Americans to "live up to the fullness of our potential" Yet we know how our society is weakened by racial discrimination which thwarts many persons from reaching their full potential. Racial discrimination in many instances fosters a despair syndrome which causes some to become incarcerated and/or debilitated from substance abuse as a way of burying their hopes and dreams. Thus, the State Department of Mental Health can be instrumental in making our society stronger by:

1. Insuring that substance abuse treatment to minorities is patient value-centered with a strong mental health component.

2. Making cultural sensitivity the foundation of treatment and making it a requirement that its presence and outcome improvements in minorities are monitored.

3. Encouraging innovative treatment approaches which are culturally based.

4. Examining identified barriers to treatment success in minorities.

5. Keeping treatment expectations reasonable and open to the minority client's unique needs and in manageable small steps.

Treatment offers hope and helps to empower the substance abuser to give up substances and to change his life style. Treatment that is reasonable and makes room for the abuser's teetering steps enables him to feel less helpless; it permits a sense of worth; it makes paradigm shifting easier to achieve.

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What Does Community-Based Violence Mean to Ethnic-Minority, Inner-City Adolescents?

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I.   INTRODUCTION

Violence is an everyday occurrence in the lives of many inner-city residents. Statistics compiled by the Federal Bureau of Investigation and published in the Uniform Crime Reports for the United States (UCR, 1991) present an overview of the extent of the problem. The number of violent crimes reported to law enforcement officials during 1991 exceeded 1.9 million offenses. The violent crime rate was highest in the Nation's cities, collectively registering 1,015 offenses per 100,000 population. The suburban counties' rate was 470, while for rural counties it was 214. These figures indicate that the victimization rate of residents in inner cities is twice that of suburban areas, making the urban centers "undeclared war zones".

The statistics on violent crimes reported in the UCR represent information on aggravated assault, robbery, forcible rape and murder. Of particular interest here is the homicide (murder) rate, which reached an all-time high during 1991 with a total of 24,703 murders being recorded in the U.S. In the Nation's cities overall, murder increased 6 percent, with the greatest increase (21%) recorded in cities with populations of 50,000 to 99,999. When compared to the figures in suburban and rural areas, which registered only a 2% and 1% rise respectively, the large urban cities are the scene of the most significant increase in homicide rates during the last year.

Youth have been particularly affected by this rise in violent crime over the last decade. During the 1980's violent incidences became a more significant component of juvenile crime, not only involving disadvantaged minority youth in urban areas, but evident in all races, social classes and lifestyles (UCR, 1991).[1] Although caution should be used in interpreting these statistics, they are useful in providing an overview of the prevalence of the problem. In 1990, the U.S. experienced its highest juvenile violent crime arrest rate to date, with 430 per 100,000 juveniles being arrested. This rate is 27% higher than the 1980 rate.

In looking at the rate of homicide in youth, the figures indicate that it is the second leading cause of death in youth between the ages of fifteen and twenty-four (Ward, 1989). Among Black males in this age group, however, it is the leading cause of death. Ninety-three percent of African Americans who perish in this way are killed by other Blacks, often by other youth (UCR, 1991). Guns appear to be the weapon of choice for the perpetrator of homicide, with figures which indicate that

in over seventy percent of all murders, a handgun was used. During the past decade, there has been a 79% increase in the number of juveniles who commit murders with guns (UCR, 1991). Taken as a whole, these statistics indicate that youth violence and homicide are serious problems in this country, and that it is particularly devastating for the African-American male population.

Conceptualization of the Problem

The statistics that have been presented regarding the prevalence of violent crime in the nation's urban centers, and the number of deaths that are often the outcome, represent the "facts" of the problem of community-based violence. However, it is necessary to develop a more comprehensive conceptualization by interpreting these statistics through the lens of a specific theoretical orientation. There are a number of different perspectives that can be applied to this data, and each one defines the problem and the appropriate solutions in a slightly different manner. For example, to someone who is concerned with public health and safety, the problem would be seen as one of epidemic proportions, making community-based violence a problem warranting national concern and intervention strategies. From the political perspective, the interpretation could be made that the statistics create an "urban war zone" where African-American young adult males are the "warriors" and where there have been heavy casualties. The solution from this perspective would be some sort of "war on violence", analogous to the war on crime or the war on drugs from past eras. The perspective taken in the study that is being discussed in this presentation is through the lens of social constructivism, which is a theoretical paradigm that is concerned with the meaning that the individuals involved in a situation give to the events that occur in their lives. It requires that a researcher look for the personal meanings that are utilized by the subjects regarding the issue that is being investigated, and to then define the problem based on these personal, subjective meanings. This subjective definition of the problem is then utilized to develop intervention services that are consistent with the needs and expectations of the group involved.

In studying the impact of community-based violence on ethnic minority, inner-city youth from a social constructionist perspective, it is necessary to conduct inquiries in such a way that the subjects are able to present the "meaning" that they give to the violent events they are experiencing in their own words. The youth need to "tell their stories" about their experiences and exposure to community-based violence, with these descriptions being utilized to develop a definition of the problem that can be further explored.

The youth who live in the communities where violence is prevalent must struggle to "make sense" of these events, and the way in which they use this information to construct a means of the violence is the variable that was under consideration in this study. To set the stage for this research, it is necessary to briefly review the existing literature on the exposure that children and youth have to community-based violence, as well as the research findings regarding the impact on

their emotional and psychological functioning. The investigation of the socially-constructed meaning of community-based violence must also begin with a review of the research findings from the literature on cognitive appraisal and ideology. Both of these concepts explore the ways in which an individual thinks about the world and what their beliefs are concerning interpersonal interactions and involvement with the environment. Through an investigation of these two ways of "making meaning" it should be possible to determine the socially constructed meaning of community-based violence in ethnic-minority, inner-city adolescents. This review of the existing literature in the area of resiliency, which is concerned with the investigation of both cognitive appraisals and ideology, will provide the underlying structure for the investigation of these issues in this study.

II.   REVIEW OF THE RELEVANT LITERATURE

Children's Exposure to Community-Based Violence

There has been a substantial amount of research over the last five years exploring the impact of community-based violence on children. The bulk of this research has focused on the development of traumatic symptoms in victims of violence, and it is now possible to describe in detail and with some precision the type of post-traumatic stress disorder (PTSD) symptoms that are often the result of victimization. Many of these studies have focused on the reaction of adults and children to discrete traumatic events, such as natural disasters and/or incidences of mass violence (Nader, et.al., 1990; Green, 1983; Terr, 1983; Pynoos, et al., 1987). Some of the research, however, has focused more on conditions of chronic danger and violence, and has attempted to explore the impact of this type of violence on children. One such researcher, Garbarino (1990), notes that chronic danger imposes requirements for developmental adjustment and accommodation in children. This is likely to include persistent PTSD, alterations of personality, and major changes in patterns of behavior or articulation of ideological interpretations of the world that provide a framework for making sense of ongoing danger. The danger that Garbarino is considering includes that which comes from the violent overthrow of day-to-day social reality that occurs in situations of war, communal violence, or chronic violent crime. He states that youth who are caught up in war and other forms of social crisis will adapt in ways that produce developmental impairment, physical damage, and emotional trauma, and will possibly be mis-socialized into a model of fear, violence, and hatred as a result (Garbarino, 1990).

Garbarino's description of the youth who are involved in these violent situations does not make the distinction between those who are victimized by acts of violence, and those who are exposed to such violence through their being "witness" to atrocities. This latter group (those who witness the violence but who are not direct victims) are only beginning to receive the attention of researchers and practitioners. These children and youth are seen as "silent, indirect victims" who often show no physical signs of harm, and they have been commonly overlooked by

those providing intervention services to victims of violence. Recent studies have shown that many children are exposed to violence in their neighborhoods, and that this exposure (as opposed to direct victimization) also has an adverse affect on children's development in many areas. It has been noted that these children develop such symptoms as being unable to function effectively in school, emotional instability, and adverse reactions to their orientation toward the future (Terr, 1983; Pynoos, 1990; Bell & Jenkins, 1991). Studies are establishing prevalence figures which suggest that this is a profound phenomenon among children who are living in the "urban war zones". A survey of elementary-school-aged children in New Orleans revealed that over 90% of the sample had witnessed violence; 70% had seen weapons used; and 40% had seen a dead body (Osofsky, Wewer, Hann, Fick. Cited in DeAngelis, 1991). Researchers in Los Angeles, CA estimate that between 10% and 20% of the homicides committed in that city are witnessed by children (Pynoos, 1985). These estimates of prevalence of exposure to violence are chilling, and in general, one can draw the conclusion that a large number of urban children are exposed to violence on a regular basis, and that this exposure produces traumatic effects that adversely affect their development and functioning.

Although the results of this body of research identify and delineate the detrimental impact of this exposure, these studies do not attempt to understand how the children who are victimized in this way conceptualize their experiences. Nor do these studies attempt to explore and delineate the factors that mediate the impact of this exposure. Questions such as these have been mentioned as recommendations for future research, and the present study begins to explore this area in more detail.

Factors Mitigating the Effects of Trauma on Children

The literature on the effects of trauma have identified a number of variables that are involved in a particular child's response to either acute or chronic states of trauma. In acute trauma, the response is effected by two categories of variables: (1) event-related, such as the origin, nature, intensity, duration and speed of onset of the trauma, its scope of impact, social preparedness, degree of life threat and suffering, and potential for recurrence of the event; and (2) child-related variables, such as life history, personality, emotional development, state of mind, autonomic regulation, coping skills, social and familial supports, and the ability to detach and deny intense affect (Turkey & Eth, 1990). In situations of chronic trauma and danger, the literature suggests that the following factors seem to be effective in mediating the impact on children: the nature of the traumatic event(s) (i.e. witness vs. participant); interpersonal factors (developmental age); environmental factors (family/social supports); and contextual factors, such as social and economic conditions of oppression and poverty (Gibson, 1989).

In clinical studies of PTSD in children, researchers have found that proximity to the violence is strongly correlated with the type and number of PTSD symptoms. As exposure increases, so does the number and severity of posttraumatic symptoms

reported (Pynoos, et.al., 1987). This study explored children's reactions following a sniper attack that occurred on their playground as school was dismissing. The researchers found that those children who knew the victim(s) of the attack suffered more severe reactions than those who did not, while those who were away from the school building on the day of the sniper attack (and unaware of the acute traumatic event until days later) had far fewer symptoms on follow-up than did children who had been at school on the day of the attack but were away from the playground when the sniper opened fire. The results from these studies suggest that proximity to the violence and whether or not one is a victim or a witness effects the severity of the reaction and the development of post-traumatic stress symptoms. Research has not been conducted, to date, to determine whether these variables also have an effect on the victims' cognitive appraisal of the violence and the meaning that they make of the experience. There has also been no research, to date, which explores the influence of these two variables (proximity to the violence and knowledge of the identity of the victims) on reactions to the exposure to violence (as opposed to direct victimization). These issues are included for investigation in the present study.

Conceptions of Violence

There is one study in the literature that is specifically focused on urban adolescents' conceptions of violence (Ward, 1989). This study seeks to understand the ways in which violent behavior is judged and explained by adolescents who have not been adjudicated delinquent or engaged in criminal behavior, but who must live in the midst of frequently occurring incidents of violence. Ward sought to give voice to a group of urban adolescents in a large public high school who were asked to reflect upon their own real-life experiences with violence. Conceptually, Ward was concerned about the different moral orientations that adolescents utilize in descriptions of real-life violent events.

Ward found that the adolescents in her sample were easily able to relate an experience of violence that they had witnessed, and the violent acts reported were embedded in a narrative of human relationships that had gone awry. She also found that no neighborhood, racial group, sex, or income level was spared from this type of exposure, in the sense that most adolescents living in the urban environment have had personal experiences of some sort with violence. Generally, the violence involved physical attacks against another person; although occasionally students chose to relate an event that involved psychological attack or pain. Ward found that the violence described by the subjects occurred in three generalized locations: (1) neighborhood and/or community; outside of the home (50%); (2) family, including immediate and extended family members and boyfriend/girlfriend relationships (25%); and (3) school and other (25%) which included violence within the school setting and such situations as violence in both visual and printed media.

The primary focus in the Ward study was to determine which moral operant concepts were being utilized by the adolescents in their conceptions of violence. She

found that, although many of the students were building upon both justice and care concerns, there were some who used an integrated category that highlighted the containment of violence. These students had a very specific perspective toward violence that caused them to consider it an acceptable response to provocation, but only up to a point. Ward concluded that urban youth may be forging a new code of "street justice" which represents an integration of justice and care morality concepts and which acknowledges, but sets limits on, the level of violence that is appropriate (and acceptable) in a given situation.

Ward's study focuses on adolescents' conceptions of violence and it provides a broad analysis of the issue; however, it is not specifically focused on community-based violence. Another limitation to its relevance to this current study is that it does not provide insight into the meaning that adolescents make of the violence. Since its primary concern is with the determination of moral operant concepts in the students' narratives, there is no effort made to explore the presence of ideology or to determine its utilization as a protective factor in mitigating the adverse impact of being exposed to chronic danger and violence. Yet, the study is useful to the current research because of its identification of the concept of "street justice" in youths' explanations of their moral conceptualization of violence.

Cognitive Appraisals and Ideological Belief Structures

The ideological belief structures in children undergoing severe forms of trauma and victimization have been investigated in war zones throughout the world. The literature, however, is silent on this issue with regards to children living in "urban war zones" in the inner-city communities of the United States. The area of research that is most closely linked to this concept of ideological belief structures is that which pertains to resiliency to stress. The concept of cognitive appraisal has been discussed in this literature, and it is seen as a significant component in understanding the factors that are related to the development of psychological symptomatology as a result of stress. Rutter (1985), in his discussion of the issue, suggests that a person's appraisal of a situation may define whether or not it is seen as positive and/or threatening. Horowitz (1979) noted that it is critically important for a person to integrate the reality of a traumatic event into one's model of the world. Similarly, Krugman (1987) noted that the meaning assigned to trauma by the victim, the family, and the community strongly affects how the traumatic experiences are encoded in memory. In general, these and other studies suggest that the cognitive appraisals that an individual makes of a traumatic situation contribute significantly to the emotional experience of that event and the psychological reactions that result.

The Role of Cognitive Appraisal as a Resiliency Factor

Although research has found that children and adolescents exposed to community-based violence experience many adverse reactions, it also has shown that not all children who witness acts of violence are uniformly damaged by their

exposure (Garmezy, 1986); Dawes, 1990; Rutter, 1985). There are differential effects of adversity on children, with some individuals seeming to be resilient in ways that serve to protect them from the most serious negative effects of trauma. One factor that has been shown to increase resiliency is the way in which the individual interprets a given stressful event. It has been found that how individuals construct meaning determines how they will interpret their situation. And, this interpretation, in turn, will effect how they respond and behave. The researchers that utilize this paradigm believe that external events (stressors) have socially constructed meanings which are used by individuals to mediate behavior. In this way, stressors have different meanings in different communities, and community discourse shapes the very notion of what is stressful and also determines what the appropriate response should be. Although social mediation does not remove suffering, it does define it, and provides a framework utilized by individuals as they attempt to make sense of what is occurring in their lives and to determine what the appropriate response(s) to the situation should be.

This resiliency literature focuses on the subjective "individual" appraisal of an event and the way in which this personal meaning ascribed to the event can contribute to feelings of helplessness or to effective coping. The results indicate that a person's response to any stressor will be influenced by his appraisal of the situation and by his capacity to process the experience, attach meaning to it, and incorporate it into his belief system. There is growing empirical support for the importance of cognitive appraisal in trauma and its role in the development of PTSD (Epstein, 1989; Kilpatric et.al., 1989). However, the studies from which these conclusions have been drawn were conducted with adult victims of trauma, usually veterans of combat who are experiencing psychological symptomatology. These concepts have yet to be applied to child victims of violence, or to children and adolescents who witness violence. This research does, however, provide some guidelines for investigating the cognitive appraisals that individuals make in traumatic situations in an effort to understand more about the coping mechanisms that can be used to help mitigate against negative consequences.

The Role of Ideology As A Resiliency Factor

Garbarino (1990) discusses the role of ideology in helping individuals function in situations of extreme, chronic danger. He notes that observers point to the importance of ideological factors in sustaining the ability to function under extreme stress, citing research that investigated this phenomenon under such severe situations as concentration camps, the liberation struggle in South Africa, and the Israeli-Palestinian conflict. Ideology, under these conditions, becomes a psychological resource and it can play an important role in shaping the consequences of experience, particularly when it is adhered to with fanatic intensity. Ideology serves as a resource for not only adults, but also for adolescents. The role of ideology is clearly evident in the psychosocial development of adolescents, and when youth are involved in struggles in which they are in any way pitted against those political institutions that represent the "status quo" in society, they participate

in a much more articulated ideology and are much more likely to be articulate about it (Coles, 1987). The openness to social redefinition that accompanies the role changes at the heart of normal adolescent development makes youth acutely susceptible to ideology as an influential factor in identity development. This heightened sensitivity to identity issues should help adolescents make use of ideology as a personal resource and protective factor that can add to their resilience in the fact of trauma and stress.

This connection between adolescent identity development and the role of ideology has particular significance to the consideration of the meaning of violence to adolescents. When youth are growing up in violent communities, they must determine what it means to be "bad", "good", "noble", "brave", and "adult". It is unclear how their wish to be a part of the "group" and to defy the adult "establishment" contributes to their participation and/or understanding of the violence that is all around them. Garbarino found that Palestinian children and youth living in the Intifada were imbued with ideology, and that many adolescents were irresistibly drawn to join their peers "on the front lines" because those doing so were viewed as heroes. These youth make sense of the violence through the lens of political ideology - they believe that they are fighting for a noble cause and it gives their experiences and their victimization "meaning". This social structure seems to provide a frame which lends significance to danger. In this situation, it may also serve to shield youth from some of the more devastating mental health problems that can result from this type of exposure to violence.

This paradigm becomes particularly important in trying to understand why some children who have been exposed to structural and interpersonal violence emerge without serious psychopathology. Dawes (1990), in studying Black children living in the shanty towns in South Africa, found that when there are adequate support systems in the family and in the community, this serves as a protective factor. Not only are the children not as likely to exhibit serious clinical disturbance; they are also less likely to develop violent life styles as an accommodation to the violence that is pervasive in their lives. He and others have also found that even when this support is absent, children have been able to avoid serious disturbance in the face of overwhelming trauma when they possess a politicized, ideological belief system. This ideological belief system seems to help the children cope more effectively because they utilize their beliefs to contain anxiety and to give meaning to their victimization. Dawes draws the following conclusions:

"...in this area children who seem to cope better are also possessed of a degree of ideological commitment to the political struggle in which they are caught up. ...One of the arguments for why more children are not apparently damaged in large numbers by political violence, might be that this adversity is given a positive meaning by the community. It transforms people from 'victims' to 'fighters' as a means of building community resilience and binding them to a political cause... [A]fter a time political violence is no longer exceptional but a normal backdrop

to society...In social constructionist parlance, political violence becomes normalized."... It seems that as children take on the symbols and slogans of political struggle, emotional stress is contained, a form of political learning is occurring, and group solidarity is promoted."
(pp. 26-27)

Although there seem to be benefits to having a politicized ideology when one is dealing with state-sponsored violence, there are also more negative consequences that can occur, since holding this type of a belief system forces individuals to take clear and definite "sides" in any confrontation between the two (or more) factions involved. Possessing this type of ideology may make it difficult to develop "negotiated peace" settlements when it is expedient to all that efforts be made to curtail the violence. Yet, in spite of this potential problem, the research findings of Dawes and others are extremely valuable in helping us understand the role of ideology in resiliency. To date, these questions have not been explored in urban youth who are exposed to pervasive and chronic community-based violence, and it is clearly necessary that these same questions be asked of inner-city adolescents in order to determine whether a similar sort of "ideology" is present, and if it can serve as a protective factor.

III. FOCUS OF THE STUDY

The literature on children's exposure to community-based violence focuses on the symptomatology that develops as a result of this exposure and on the adverse effect of violence on children's development and functioning. As stated in the literature review, there are few studies that attempt to understand the way in which children and adolescents understand the violence - how they "make sense" of what is occurring in their world and their own conceptualization of the reasons that it is happening. The current study is an attempt to address these questions and to begin to fill in the gap that exists in the literature. It is an effort to investigate the cognitive appraisals that ethnic-minority, inner-city youth make of the violence that is pervasive in their communities, and to utilize this information to suggest an approach to intervention. The residents who live in these communities must attempt to incorporate the violence into an understanding of their world, and the ways in which they utilize this information to construct meaning about the violence and to respond to the situation should be helpful in developing intervention strategies.

Limitations in Previous Research

In addition to the limitations that have been cited in the previous section with regards to the applicability of the existing research to the population of inner-city youth who have been exposed to community-based violence, there is an additional limitation in the literature on the "silent victims" that needs to be considered. Two studies that are the most relevant to the proposed study are

illustrative of this limitation. In Garbarino (1992) there is no systematic way of determining how many of the "silent victims" in his sample were also <u>actual victims</u> of violence. The way in which the data was reported makes it impossible to determine whether the subjects who are "witnesses" have, at any point in the past, been "victims". It is also unclear whether they are "survivors" of family members and friends that have been victims of violence. Most of the studies in this area appear to combine the populations of children who are victims with those who have witnessed violence in order to conceptualize the issues and to draw conclusions. The children are often the "silent victims" of poverty and chronic danger, as well as having had the types of personal experiences with tragedy and loss that make them direct victims of violence as well. This also appears to be the case in the study conducted by Ward (1989). There is no attempt made, according to the data reported, to determine whether the adolescents that she interviewed had been victims of violence in the past, or if they had been, at any point in their lives, perpetrators of violent acts.

Although the significance of these and other variables on the impact of exposure to violence in children has not been clearly established in the literature, researchers have raised the questions and have indicated that this is an area for future research. In their discussion of these issues, Bell & Jenkins (1991) conclude that there is a desperate need for more research on the circumstances and extent of the exposure to violence, and on factors that mediate the impact of this exposure. They indicate that little is known about the effect of such variables as knowing the identity of the victim and/or perpetrator; the significance of the relationship of the victim (or the perpetrator) to the witness; or how circumstances surrounding the violence affect the extent or severity of traumatic reaction. The question is also raised in regards to the factors that may buffer children against the deleterious effects of witnessing violence. Although Bell & Jenkins make no specific reference to the concept of ideology, they do query whether ethnic identity and/or religious values might serve to buffer African American children against the impact of victimization or witnessing violent acts. Thus, the questions are beginning to be asked by researchers with regards to the variables that may affect the impact of <u>exposure</u> to community-based violence, in addition to concerns about those factors that might mitigate this impact.

Clearly, there are many unanswered questions in the research literature pertaining to children's response to exposure (and witnessing) violence, and the current study can in no way address all of these concerns. However, it will make an effort to address the issues of (1) experiences of personal victimization; (2) proximity to the violent act that was witnessed; and (3) the witness having knowledge of the identity of the victim(s) and/or perpetrator(s) in the violent incident as it attempts to delineate the socially-constructed meaning of community-based violence in this population of adolescents.

IV.   METHODOLOGY

A.   Subjects

The subjects for this study were drawn from a population of inner-city adolescents (14-20 years old) attending a Therapeutic High School located in Boston, MA. A total of 10 youths (male and female) were interviewed and were taken from those students who volunteered to participate in the study on the two days that the interviews are being conducted. The student population in the school includes White, African-American and Latino adolescents. The results discussed in this presentation focus only on the students of color who participated in the study (N = 3; 1 Biracial; 2 African-American; all males). Those subjects who indicated that they had never witnessed a violent incident in their community (N = 1) were excluded from the study.

The young people attending this Therapeutic High School can be considered to be very much at risk for exposure to community-based violence due to a number of factors: (1) they have academic problems, complicated by emotional and behavioral difficulties; (2) they have been unable to be maintained in the main-stream program at their high schools; (3) they have been involved in the Juvenile Justice system; and (4) most have some degree of dysfunction in their families. These factors contribute to increasing their risk because of their effect on success in school, and a redirection of the adolescents' energy into a focus on their friends and the activities that they participate in outside of the school setting. This population was specifically chosen for the first study in what will be a broader research agenda because of the belief that these young people are currently at risk, and are in need of intervention.

B.   Design

The present study is qualitative in design and exploratory in nature. It elicited narratives from this group of adolescents where they were asked to describe a situation where they witnessed an act of community-based violence. Additional data was obtained from both an unstructured interview and a structured questionnaire. For the narrative description of a violent incident, the students were asked to respond to the following question"

> *"Have you ever been present or seen a violent situation in your neighborhood, or one in which someone was being hurt outside of their (or your) home? Tell me what happened."*

At the completion of the narrative, the students were asked a series of questions that inquired into their thinking about the incident and which ask them to provide an explanation for why the violence is occurring. The unstructured, interview protocol included the following questions:

1. Why do you think this happened?
2. Do you think the people involved were right or wrong in what they did?
3. What was right? What was wrong?
4. Why do you think so much violence is happening in (name of community where subject lives)
5. Why do you think there are so many guns available on the streets of ( ) today?
6. What rights do people have to protect themselves from guns already on the street?
7. What can (and do) you do to protect yourself on the streets?
8. What do you think should be done to stop the violence?

Each subject was interviewed individually, and the interviews were audio taped (and transcribed at a later date). Clarification and probing questions were utilized whenever necessary to help the subjects provide the most comprehensive responses that are possible.

In addition to the unstructured interview, subjects were presented (orally) with the questions from a structured questionnaire. These questions referred to demographic information and inquired into incidences of direct victimization and the subjects' experiences with close family members and/or friends having been victims of severe violence (homicide; gang violence; assault; rape). Information regarding specific aspects of the violent act that were witnessed and reported on in the narrative were also solicited, including the subjects' proximity to the act and whether or not the identities of the victim(s) and/or perpetrator(s) were known to the subject.

Operational Definition of Community-Based Violence

The literature dealing with the effects of violence on children contains studies that focus on many different forms of violence to which children are exposed. There is domestic violence, suicide (of a family member), homicide (both within the family and the community at large), rape, street crime, and juvenile gang violence. For the purposes of the present study, community-based violence was operationally defined as:

Violence that occurs outside of the home and that includes street crime, gang-related violence, and the type of violent acts that effect an entire community (such as sniper shootings, kidnappings, and mass murders).

Operational Definition of Ideology

The concept of ideology has been discussed in the literature on resiliency, and it is concerned with the way in which an individual understands the reasons why certain life events are occurring. Ideology is one's belief system regarding these life

events and it provides a way of interpreting them, which in turn, helps an individual decide how to emotionally and behaviorally respond. For the purposes of the present study, ideology was operationally defined as:

> *The belief system utilized by inner-city adolescents to explain and/or interpret the community-based violence that is occurring in their neighborhoods.*

Data Analysis

The study was exploratory in nature, and the data analysis involved determining themes in the subjects' narratives that dealt with morality and ideology with respect to their experience of community-based violence. Previous research has concluded that urban adolescents utilize three orientations in their moral judgments of violent acts: (1) care; (2) justice; and (3) an integrated category that is reflective of "street justice" (Ward, 1989). The third category, street justice, was of particular concern in the present study. The narratives provided by the adolescents as well as their responses to both the unstructured and structured questionnaires, were analyzed to determine the themes that were used to describe why they believe the violence is occurring in their communities. These themes provided some insight into the type of ideology that these adolescents are utilizing to make sense of their experiences.

IV.   RESULTS

Due to the time constraints for the presentation, the students' responses to five specific questions will be the focus of the discussion:

1.   Why do you think so much violence is happening in ( )?
2.   Is anybody right? Wrong?
3.   Why are there so many guns on the streets?
4.   What can (and do) you do to protect yourself on the streets?
5.   What do you think should be done to stop the violence?

In response to Question #1, there were two themes that were involved in the youth's answers: (1) drugs/alcohol; and (2) personal frustrations and anger. Drugs and alcohol are believed to be involved in the violence on two levels: the gang-related activities associated with selling drugs, and the negative effect of drinking and/or using drugs on one's own ability to cope effectively with situations. The second theme, personal frustrations and anger, was reflective of a sense of boredom that the students talked about experiencing, with the belief that some of the fighting is due to the fact that "kids have nothing better to do" or because of "jealousy" over relationships and/or possessions.

In response to Question #2, none of the youth interviewed felt that the violence was "right". They all indicated that no one was "right" in these situations, and they believe that there should be an alternative to the violence. One young man was particularly eloquent about this situation. He stated:

"All the kids around there, all the stuff that is happening, they grew up together. So now, if they split up and go their ways and join different gangs, they gonna come back together. They shouldn't even fight each other. They should talk it out. If they got some differences, they should stay away from each other, that's how I see it. God didn't put us on this earth for people to be fighting' each other."

The young man who made this statement has witnessed a number of shootings and gang fights. Although he has not personally been victimized or hurt, he has had brothers and cousins that have been seriously injured and/or killed as a result of gang-related and random street violence.

In response to Question #3, the major theme presented by the young men interviewed indicates that they believe guns are necessary for protection, that guns are the only effective means of protecting oneself and one's territory in the "drug business". There doesn't seem to be any clarity with regards to where the guns are coming from; however, all of the young men were clear about how easy it is to obtain a gun illegally. For these young men, guns don't seem to figure into the violence unless it is related to the selling of drugs. In their description of fighting - either fights that they witnessed or in which they participated - knives play much more of a role as the weapon of choice.

In response to Question #4, the young men seemed to have resolved the problem of safety on the streets by staying off the streets. Each one indicated that they no longer just "hang out" after school. They stated that they spend most of their leisure time either at home or in the homes of friends. One young man responded to the question this way:

"I'm a house kid. I'm not saying that I'm in the house all of the time. I hang out with them [my friends/cousins] but when they are going to do something disruptive, you know violent, that's when I leave... I go home... I don't get into that peer pressure stuff. I don't believe in it..."

These young men also made a point of indicating that they mind their own business when they are out on the streets. In this way, they feel that they can avoid the trouble and stay safe.

In response to Question #5, the young men all had similar ideas regarding what is necessary to change the situation in the community. Each indicated that there is a need for more youth activity programs - safe places where adolescents can gather with friends and have fun. The other need that was expressed was for jobs.

Although they were aware of the problems with minimum wages, they indicated that they wanted to work and were frustrated because there were no jobs available for them. One young man stated during the interview, with obvious excitement in his voice, that he thought he was about to actually secure a job. The school staff had been helping him and he thought that one of the positions he had applied for might actually come through. In this particular case, this was a very significant statement because this young man had been very involved in gang activities during most of his adolescence, and had spent a year in Billerica House of Correction following a stabbing incident.

The young men also discussed the poor conditions that exist in the recreational facilities in their communities, and the need for more attention to the places where children and adolescents are able to play. One young man also discussed the role of parents in the situation - that the parents need to be aware of their children's activities and to provide appropriate role models and supervision. This same young man indicated that the parents are either doing drugs or getting drugs to sell from their adolescent children. He was not alone in his indictment of the adult world, as some of the other majority-group students shared in this perception.

V.   CONCLUSIONS - What Does Community-Based Violence Mean?

This is a very small study and the results should be viewed as only suggestive of the socially-constructed meaning of community-based violence in ethnic-minority, inner-city adolescents. The young men of color that were interviewed for the study had not only witnessed acts of violence in the community, but had also been directly victimized (either stabbed, beaten up, or attacked with a gun) and had participated in violent acts as perpetrators. They all knew friends and/or relatives that had been direct victims of violence, including victims of homicide. From the comments that they made during the unstructured interviews, and from their narrative descriptions, it is possible to conclude that community-based violence is a regular occurrence in their lives, and that they generally know one or more of the victims or perpetrators involved in the incidents that they witness. Their perception is that the violence is gang-related and that it generally involves drugs. The violence is never justified - it is never right. It is simply inevitable, sort of an "occupational hazard" of the drug business. Given this perception of the violence, the only way that they believe they can avoid becoming involved (either as a victim, perpetrator, or witness) is to stay off the streets.

The solutions to the problem of community-based violence proposed by the young men are reflective of their perception. They suggest increased community activities and jobs - all socially-acceptable ways to stay off the streets, out of trouble and to not become bored staying home. These young people see the solutions as coming from the "system" in the form of increased community activities and job possibilities. They don't seem to have a sense of personal empowerment - the only

thing they feel they can do is to stay away from the violence by being at home or at community centers. They also seem to feel that there is a role for parents in the solution, but this role is poorly defined and there is some indication that the youth have lost confidence in their parents (and other adults) because of the latter's involvement in the drug scene.

The results of this study suggest that these young men possess an ideology that does not involve personal empowerment or any assessment of the larger socio-political influences that contribute to the maintenance of drugs and violence of the inner-city communities of color. Their solutions are reflective of a sense of helplessness, with regards to a belief that they (themselves) can do nothing to change the situation. They believe that one must rely on the benevolence of "the system" to provide additional resources. In order for the "system" to be responsible, it would require a major change in social policy, such that more community activities for youth are funded and implemented, and jobs are made available for adolescents who have limited skills. It is unlikely that this type of systematic change and responsiveness will be occurring in the near future. The existing violence prevention programs, to this writer's knowledge, are still focused on the "individual" and changing the way in which youth resolve interpersonal conflicts. This is not to say that this sort of prevention effort has no role in the solution. It will, no doubt, be of help to adolescents to provide them with alternative strategies for resolving conflicts. But, this will do nothing to change the conditions that underlie the gang violence that the young people interviewed for this study talked about. This violence is related to drug trafficking, which is the result of economic deprivation and closed-off options for poor ethnic-minority youth. There will be little change in the conditions that underlie the community-based violence in our inner-city communities without some solutions being formulated that are directly related to the conceptualization of the problem - and the youth describe a different problem than the one that the mental health community has articulated to date.

As stated earlier in this presentation, the focus of the study was on the youths' ideology - with their belief system surrounding the experiences of violence and their perspective on the interaction between the individual and the environment. The ideology presented by the youth interviewed in this study serves to keep them functioning in "survival mode", in the sense that the violence is inevitable and unavoidable unless an individual "minds their own business" and "stays off the streets". These adolescents clearly believe that the violence is connected with drug trafficking, but this is where the analysis seems to stop. From the research that has been done with youth living in countries that are at war, it has been found that having an ideological perspective on the violence that clearly identifies the "enemy" and the "victim" can serve to mitigate the negative impact of the violence. This sort of ideology also seems to help because one is able to interpret the violence and victimization from the perspective of social activism, where one can become a "freedom fighter" because of one's stance with regards to the violence. Based on the interview data that was obtained from this small sample of adolescents of color, there does not seem to be a clear delineation of who is the "enemy" and

who is the "victim". No one is perceived as being "right" in the violent situations described, and the youth seem to know individuals who alternate between the "victim" and/or the "perpetrator". There is no clear perception of a <u>cause</u> involved in the community-based violence in the inner-cities. It is a matter of people trying to establish themselves in the drug business, protecting their "turf", retaliating against perceived injustices, or dealing with interpersonal conflict situations that are characterized by jealousy. One is either involved in the drug-related activities, and so becomes a victim or a perpetrator depending on the situation. Or one is an innocent bystander, where the violence is random and unpredictable.

It seems possible to conclude that the ideological belief system that has been constructed by this group of ethnic-minority, inner-city adolescents can not serve as a mitigating, protecting factor in its present form. The belief system that is in place interprets the problem of community-based violence from an <u>individual perspective</u> - the individual has to decide how he/she will respond to the violence, whether to avoid it or to get involved in the fighting. Even the solutions proposed by the youth are individualized - more community activities so that youth can have alternatives to the streets; increased involvement of parents with their own children. It would seem only that a belief system that provides a way for them to see beyond the survival <u>of the individual</u> could serve this sort of a protective function. The youth do not express a sense of community activism or community empowerment. Somehow they, and we, seem to have lost the <u>collective sense of community</u> - an approach to the understanding of the problem and to the solutions that involves more than the individual; one that sees the plight of the individual as the <u>plight of us all</u>. As mental health providers, we can not afford to continue to think of the problem of community-based violence, and the solutions, only from the perspective of the individual - it is not an individual problem so the solutions can't come only from the individual perspective. The violence is affecting the community as a whole, and even if one (or one's child) is able to escape becoming a victim, one still has a responsibility to be involved in a collective solution.

The data from this study can be applied to the concept of <u>ideology</u>. They suggest that an effective, protective ideology should be one that broadens the understanding of community-based violence to include a socio-political awareness of the causes of community-based violence; one where the problems of drug- and gang-related violence are seen as being <u>aided and abetted</u> by social and political forces that go beyond drug dealers and gang members. Since this study's results (although limited) suggest that ethnic-minority, inner-city youth do not currently have this perspective, it is being recommended that such an ideology be "taught" to the youth by the adults who are responsible for their socialization and caretaking. Being "taught" is not the same as indoctrination, but involves providing young people with the necessary information to have them begin to think about the problem from a broader perspective. The problem of community-based violence should be talked about in our schools, with adolescents being given information about the history of the illegal drug business in the U.S. and how it has gradually become concentrated in the urban centers of this country. They should be given

information regarding the role of law enforcement in the prosecution of drug dealers, and information about the way in which money is laundered by some main-stream business and banking establishments. This information exists in the public sector - but our young people are not being given opportunities to learn about it. As they attempt to "make sense" of the situation, they utilize the information that they have at their disposal to explain why it is occurring. It is strongly recommended that this base of information needs to be broadened, having confidence in the fact that the young people will do whatever is necessary to incorporate this information into their conceptualization of the problem in ways that are empowering.

It is the responsibility of the adult world (and in particular mental health providers and educators) to provide them with the necessary tools to improve their adaptation and coping skills. The development of this type of a broadened perspective on the problem is the foundation for the development of a sense of community activism. As the youth begin to understand the complexity of the problem, they will begin to move away from the interpersonal, individualized domain and to move into a sense of needing to work "from within" to bring about change. The community services and activities that the youth are calling for can, and should, be provided by "the government". But, in essence, we are the government, and these services can be provided from within our own community. We have the strength and the power, as a collective community, to clean up our parks and to provide recreational facilities for our adolescents. We also have the business contacts and connections to force the broader business community to provide jobs for our young people. And, as a collective group, we have the political clout to bring about substantial changes in the local, state and federal institutional systems that create and maintain the severe levels of poverty under which residents in the urban centers must struggle to live. But we must first perceive the problem of community-based violence as our collective problem before we can develop solutions that reflect this perspective.

As mental health providers we must become aware of our involvement in the definition of the problem of community-based violence. As long as we design and implement interventions that are focused on changing the individual, without sufficient attention to the broader perspective, we are part of the problem and not part of the solution. Many of us have direct access to the types of youth that were interviewed for this study. We need to realize that we have to help these young people develop an ideology that will empower them; one that will give them a way to psychologically ward off the negativity and sense of helplessness that they experience with regards to the violence that they must live with on a daily basis. What is being recommended is a shift in perspective of the "helpers" so that young people can be assisted in making this shift as well. It is our job, as mental health providers, to provide the tools the youth need in a way that helps to bring about empowerment from a perspective of collectivism. This will clearly not be an easy task. But children of color (our children!) are being physically and emotionally violated, and in many cases are dying, as a result of the violence that is pervasive in

many urban communities, and it is imperative that we as mental health providers heed the "call to action" in as many different ways as possible. Attempting to help young people develop an ideology that is liberating in the face of the tragedy of urban warfare is one way to respond to this call.

Footnote

[1]The UCR utilizes arrest records as an indicator of crime trends, and the data is delineated by ethnicity of offender and category of crime. These figures, however, are questionable since there may be many uncontrolled factors that affect who is actually arrested for a crime. The figures do not control for such variables as institutional racism and differential police surveillance and prosecution across different socioeconomic and ethnic groups.
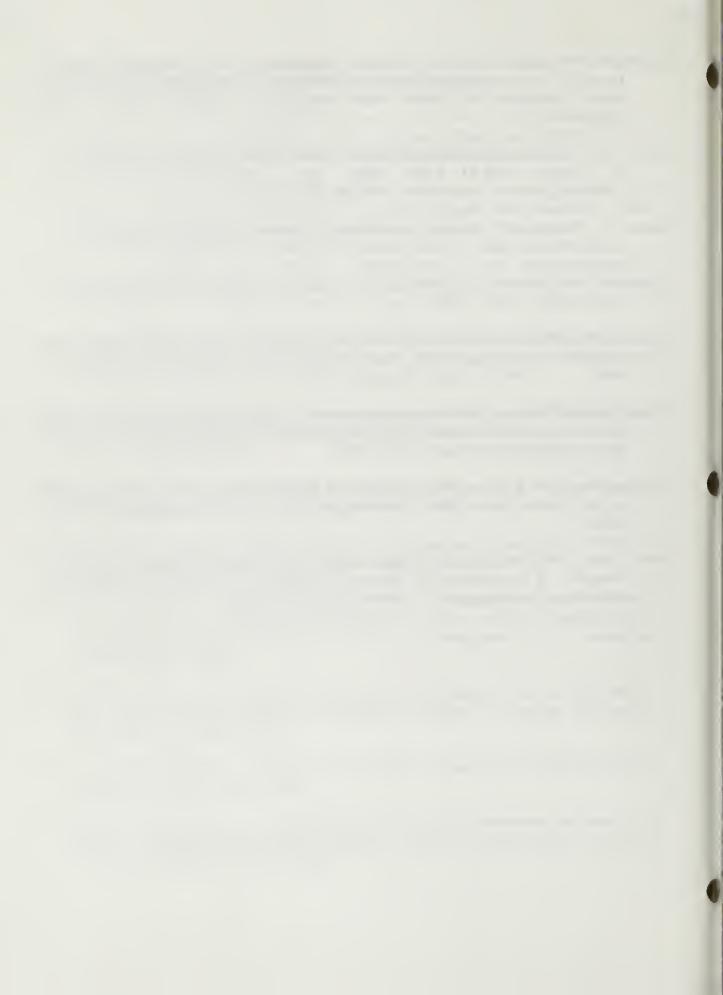
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PSYCHIATRIC TREATMENT OF SOUTHEAST ASIAN REFUGEES

(Cambodians/Khmers, Laotians/Laos, Hmongs, and Vietnamese)

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Introduction

Southeast Asian (SEA) refugees are from war torn countries, Laos, Vietnam and Cambodia. These refugees prefer to be called "Khmer/s instead of Cambodian/s, Lao/s not Laotian/s, Vietnamese not An-Nam, and Hmong/s for Hmong/s which means "free man." Almost all of the Hmong/s for Hmong/s which means "free man." Almost all the Hmongs in this country came from Laos (Bliatout, 1979a).

SEA refugees experienced trauma in varying degrees, depending on multiple deprivation, the time they escaped from their own countries, length of time spent in the refugee camps, and frequency of moves while staying in refugee camps and in the USA. The adults over age 40 tend to be the most traumatized, with those in their 30s slightly less affected. Those who are about 20 years old are traumatized more than young adults who are under 20 years old. This is because the adults were tortured by the Khmer Rouge leaders, witnessed killing scenes, were raped, separated from the family members, forced into labor for long hours each day, faced starvation, lacked medical supplies, and lost loved ones. In addition, they once again experienced family separation, starvation, interrogation, violence, harassment, detention, and deportation by the border police while seeking a refugee camp. Coburn (1992) stated that the journey to the United States could also be dangerous and traumatic both for those fleeing political oppression and those seeking economic sustenance. However, children who were born in the refugee camps or in the USA may also absorb parents' feelings and emotions such as depression, fears, and feelings of insecurity. If the parents consume alcohol or use sleeping pills to help them to forget traumatic experiences or escape from their inability to adjust to American culture and/or geographical and weather differences, the children often follow the adults' footsteps. In addition, most refugee children take on more responsibilities more than American children. Not unlike many others before them, these immigrant children are able to acquire American language and culture faster than their parents (Coburn, 1992). Therefore they end up taking on stressful responsibilities such as translating, managing the household, and negotiating the U.S. bureaucracy.

SEA refugees came to the United States without knowing what their lives would be like. Most of them expected that they would have better lives, high education, happy marriages, early large incomes, have big, beautiful homes, fancy cars, pretty clothes, go to elegant restaurants, night clubs and bars for entertainment. According to their high expectations, life should not be different from the way they grew up before the war started. On the contrary, they find themselves being confronted with unforeseen issues such as Adjustment Disorder (both social and geographic), Post-traumatic Stress Disorder, Depression, Anxiety Based Disorders, Alcohol and Substance Abuse, Domestic Violence and (once again) rape and sexual assault by native friends or Americans (Suksawat, & Phay, 1993). These problems are seen in both adults and their children. In addition, they have contributed to a high rate of unemployment and a high rate of school drop-outs, teen pregnancy, and gang involvement for the SEA teenagers. These young adults often report that they are unable to cope with the deleterious effects of the family's structure, parents' psychiatric behavior, domestic violence, rape and sexual assault either toward themselves or their family members. The anger, fears, trauma, lack of understanding and support, inability to access medical and legal services, shame and rejection from the family and community made them seek attention from peers, gang members, and to depend on alcohol or illicit drugs to forget such traumatic experiences.

In general, Southeast Asians are truly interested in the quality of human relationships, how people feel, react, and interact with one another. They place high values on humanism, independence, individuality, self-reliance, hard work, peace and harmony in life. About 85% of Southeast Asians are influenced by Buddha's teachings and principles. In general, they are polite, sensitive, patient, considerate, humble, but also quiet and shy. They appear passive at times, due to the aforementioned and the way they communicate and handle their social interactions in this country in addition to their language barriers.

Families are very important in the Southeast Asian's life. Age means wisdom, experience and knowledge, and it deserves respect. They treasure education. Unfortunately, before they came to the USA, almost all of Southeast Asian refugee children and adolescents had no prior education due to the civil wars. Parents who were younger than forty years of age were being used in the war instead of being in school. The children were also being used for farming and labor during the Khmer Rouge regime. In addition, more than 80% of the refugees were tortured by the Khmer Rouge which resulted in mental health problems, as well as physical handicaps to different degrees.

In Southeast Asia, the heads of the family are proud men who are self-sufficient. Once in another country, their image changes and they often feel incompetent. They are very often unemployed, under employed, or under the supervision and charity of churches or voluntary agencies, and receive public assistance. In addition, many SEA refugee families incurred post-traumatic experiences and physical injuries while living under the Khmer Rouge regime or

while moving away from their countries to other countries for safety. Such trauma is particularly common for Cambodians, where it is estimated that one-third of the population died from violence or starvation during the brutal Pol Pot regime (Coburn, 1992). This condition also created depression, adjustment disorders, anxiety based disorders, personality and conduct disorders, and alcohol and substance abuse in both adults and children while living in refugee camps and in the USA. Some of them experienced physical and emotional abuse, in particular rape and sexual assault during the civil wars, while living in the refugee camps, or during resettlement in the USA. Almost all of the victims and their families keep secrets about the incidents in hopes that they will forget and have a better life. They have never received medical or mental health attention due to the fact that rape and sexual assault are taboo subjects for the SEA community. Many SEA refugee women are facing domestic violence and are unable to seek help due to fears, shame, saving face, guilt, the language barrier, and insufficient services from agencies and care providers who are unfamiliar with their cultural backgrounds and languages. In addition, there are a limited number of practitioners with proper training and similar cultural and language background who can provide services for Southeast Asian refugee families (Suksawat, 1992). Oftentimes, interpreters are being used in crisis intervention, counseling, and assessments in mental health agencies in order to provide services for the refugee survivor. Translations that practitioners have received often vary in quality because it is difficult to find interpreters with adequate English skills. Interpretation and translation create situations in which a practitioner does not have enough knowledge and experience and may therefore misdiagnose, or mis-refer, mis-treat, or prescribe medications that do not suit the refugee patients/clients because of the interpreter's performance. On many occasions, interpreters lack concern regarding "confidentiality/legal matters," and lack respect for the families' rights.

The children are sensitive to any changes in their life and they can feel the uneasiness of their parents. They themselves become confused and afraid that the same fate will befall them when they grow up. In addition, SEA teenagers seem to have difficulty following parents who are conservative and wish to keep their culture. They are sensitive to any changes in their life. In addition, they are very insecure and unhealthy. Some of them are addicted to alcohol or prescription drugs, and some others become physically or emotionally abusive to their wives and children. In addition, they face serious obstacles: To be accepted by American peers and American society, who view SEA refugees as new and strange. This predicament drives them to seek comfort from either native friends or familiar Americans. As a result of these difficult circumstances and unfit situations, some become promiscuous and oftentimes experience rape and sexual assault. Some become unwed mothers, or drop-outs, and others become addicted to alcohol and illicit drugs. Those who desire revenge often become involved with gangs to gain acceptance and power. SEA refugee students who drop out are faced with homelessness, hunger, lack of medical attention, mental health problems, litigation, unemployment, inability to care for their own children, and abuses. In addition, these refugee teenagers are limited in their ability to speak English which makes it

even more difficult to receive help or continue in both medical and psychiatric treatment.

There are many adjustments that both adults and their children have to go through together. They learn and experience the new culture and systems in the schools, work place and the social environment, which in turn leads both children/adolescents and parent to learn and pick up various aspects of the American culture. These "absorbed" aspects may or may not be socially appropriate AMERICAN traditions and behaviors. Adjustment for SEA refugees is considered essential when providing support and services for them (Fraser & Pecora, 1986, & Williams, 1985). Also, they have a difficult time in adjusting to the seasonal weather, especially cold weather. They also lack knowledge of the means to access the services of the American system appropriately.

Method

This study is based on the author's professional direct experience working with SEA refugee psychiatric out-patients, as well as the author's data and notes to promote psychiatric treatment for SEA refugee survivors. One hundred SEA refugees with age ranging from 19 to 65 were referred for psychiatric treatment from 1990 to 1993. They were screened, diagnosed under DSM III-R classifications, and received out-patient psychiatric treatment. This study emphasized diagnosis, treatment plan, family involvement, and the use of interpreters assisting in the treatment process. As psycho-pharmacology was also an integral part of the treatment plan for some patients, both they and their family members were educated about the proper use of medication as part of the treatment.

Referral and Entry

Patients receiving psychiatric treatment are usually referred by authorities such as court order, Department of Social Services (DSS), School System, Buddhist monks, community leaders, or minority linguistic organizations, and respected adults in the family. Depression, emotional pain, family problems, and poor adjustment are viewed as signs of weakness in SEA culture. Revealing problems to others who are not adults in the family or close friends is considered a wrongful practice and brings shame, loss of face and rejection from the family. For those who have severe psychiatric symptoms, these symptoms are often considered a punishment from God, or the results of black magic which is known as "Mone-no-Kum , or Toog-Khong". Muecjke (1979) stated that it was also an identifiable array of an individual's attributes. The patients have often received water blessing from the monks, herbal medication, and western medication for somatic symptoms for many years before receiving western psychiatric treatment in this country.

In my experience from 1992 to the present, there are patients who seek psychiatric treatment because they have seen positive results from family members, friends, and acquaintances in the community. This is because SEA refugees view the term "Mental Health" as "Mental Illness" (Bliatout, 1979b) due to lack of understanding and limited educational background. Many patients and their family members still keep psychiatric treatment a secret. The author has often overheard one patient telling another patient or his family members that he has depression rather than schizophrenia. Many times, patients request appointments with therapists or psychiatrists on a different day from those who have the severe symptoms seen in particular psychotic or bipolar patients.

Diagnosis of SEA Refugee Patients

My observations have been that SEA patients are reserved individuals. If a patient is seen by an American practitioner, he often questions if the care provider understands his culture and background. They rely on interpreters to convey their message and symptoms to care providers. In addition, self-disclosure to a stranger (professional) is not considered normal for patients. Oftentimes, they assume that interpreters have the same experiences as themselves. In some instances, interpreters either give too little attention or desire too much involvement with the patients, which leads psychiatrists and therapists to misdiagnose. In addition, some interpreters have poor language skills which contributes to these difficulties. Tung (1985), reviewed interposition of an interpreter as an aggravating circumstance, and mentioned that there were few SEA auxiliaries that could offer the transparency that professional translators must attain to avoid interposing themselves in the dialogue during translation. Very few interpreters or translators are fully qualified professionals to work under supervision after only brief training, although some are able to function in such unique circumstances. Their role and contributions is invaluable, but complicated by problems that have not been sufficiently examined (Lique 1982, Tung 1983b, Tung et al. 1978, Weiss and Parish 1981).

When a care provider interviews the patient, the interview should not include the spouse or children in the session unless the patient has a poor memory or he is confused. However, family members should be included in the family sessions as soon as the care provider is able to relate to the patient. If a patient is a minor, parents or guardians should be included. If treatment is given only to the patient, he may not receive support which may impede treatment. To many Southeast Asians, psychological problems and conflicts do not make sense. The head of the family may refuse to cooperate and may forbid the member to receive help, which may not be due to a lack of love and concern but to lack of understanding about this kind of treatment. The use of the community model as the primary approach is suitable to assist the family in seeking assistance on the personal, social and institutional levels. An influential member of the community should be used as a resource to influence the family towards seeking therapeutic help individually and as a family.

During the interview, the family background should cover the following: patient's childhood, his parents' and spouse's family background, life experience before the war, during the war, reason why and how they escaped, life in refugee camps, expectation of life style in the second or third country, sponsorship, resettlement, psycho-social and geographic adjustment, present living situation, relationship among family members and between their friends, acceptance in the community, marriage, financial and employment status, educational background, and any alcohol or drug abuse. Alcohol abuse is often difficult to determine as alcohol is often used to mix with herbs for traditional healing.

Most often patients are diagnosed as having Post-traumatic Stress Disorder. There are some symptoms such as revisualizing traumatic scenes or flash backs that are often misdiagnosed as having hallucinations due to inaccurate interpretation and translation. However, if the care providers are familiar with SEA culture and their beliefs, the diagnosis is always correct. In addition, patients who have no transportation, limited English or no English, seldom go out and lose track of dates, are often misdiagnosed as having Agoraphobia. Care providers who are unfamiliar with Mongolian spots/birth marks, marks on the body after receiving eastern healing such as coining, cupping, or pinching, often diagnose patients as suicidal or victims of family members who are abusive or homicidal. Their diet also confuses some practitioners who misdiagnose patients as Anorexic.

Major Depression and Anxiety Based Disorders are often found in the SEA refugee patients because they have never received psychiatric treatment after their depression started during the civil war. In addition, difficulty adjusting to changes both psychosocial and geographic have worsened their symptoms. This is also found in their children.

Teenagers often show defiant behavior because of their inability to adopt and adjust to American culture due to lack of adult role models in the family who are important for SEA children. Some are addicted to alcohol and illicit drugs because of peer pressure and rejection of their roots.

Treatment

The treatment of SEA refugee survivors/patients is complicated by their politeness, passive like behavior, smiling face, and "best side" portrayed by the patient. They need encouragement to receive treatment regularly, and need to be reminded of the appointments because they are unable to read and write. Dates and names mean nothing to them due to lack of contact with others outside of the family. In addition, time is considered "elastic" on account of geographic background and the harsh conditions of war. However, they do have the potential to get better. Mollica, Wyshak, Lavelle, and Troung (1990) revealed that SEA refugee survivors of multiple trauma and torture can be helped by psychiatric care.

Most patients expect the practitioners to give them medication to heal their trauma, depression, anxiety, fears, insomnia, poor appetite, fatigue, and somatic pains such as headaches and body pains. Oftentimes, patients do not take medication as prescribed, nevertheless, they get better due to confidence in the practitioner and treatment.

Because SEA refugees are part of extended families, individual therapy does not appear to support the establishment of rapport among the patient, his family, and the care provider. In addition, most SEA patients under psychiatric treatment do not receive appropriate intervention until their symptoms are severe and they are unable to help themselves. These patients often benefit from family members' support and involvement of extended family members.

Family therapy seems to be most beneficial for the SEA war survivors. However, it seems to be difficult if male interpreters assist in treatment. The husbands would not disclose family problems for fear of losing face. Female interpreters seem to be less intimidating for the husbands. Family members' involvement is important for the patient because to many Southeast Asians' mental health, psychological problems and conflicts do not make sense. The head of the family may refuse to cooperate and may forbid the member to receive help, not because they lack love and concern but because they fail to understand this kind of treatment. In addition, family members, in particular children and females, must follow the head of the family or husband's requests or orders.

Group therapy is sometimes seen as a threat for the patients because the procedures are seen as somewhat similar to meetings under the Khmer Rouge regime. Patients deserve explanations of treatment plans, procedures, and prognosis before their participation in group therapy. In addition, "Confidentiality and rights" must once again be explained.

Psycho-pharmacology is important in the beginning of the treatment due to lack of medical and psychiatric attention since the civil war started. In addition, most of the patients often have severe psychiatric symptoms when entering the treatment. Later, patients seem to accept and enjoy psychotherapy more than taking medication. In addition, practitioners should inquire about the number of physicians the patients have seen before and during receiving psychiatric treatment. Many psychiatric patients may take other medication besides those they receive from their psychiatrists. They believe that many physicians and medications will help them get better sooner.

Receiving blessings from the elderly and monks should encourage patients if they believe in Buddha. Prohibiting patients from doing so may exacerbate the psychiatric symptoms. Opstead (1990) & Bruno E. & Kuras, E. (1984) have argued that acknowledgment of the holistic view and spirit world not only bridges cultural gaps but also promotes physical and mental health.

Rape and sexual assault are taboo subjects for the patients' family members. Therefore, family members must participate in family therapy in order to treat rape and sexual assault survivors. Without family support, the rape survivors are often suicidal due to rejection, shame, guilt, and feeling punished by the family and God.

Treatment of alcohol abuse is complicated by cultural attitudes which involve use of alcohol in preparing herb medication. In addition, for those who are unable to attain appropriate medical attention, self medication through traditional herbal preparations is well known and well accepted.

SEA patients take a longer time to disclose personal or family problems than American patients. This may create a lengthier period of treatment than the practitioners expected (Suksawat, 1992).

Discussion

During 1990-1991, patients and their families entering treatment were referred and convinced to do so by various authorities, i.e., court order, DSS, etc. However, patients who received treatment from 1992-1993 tended to seek help on their own, in particular battered women and Post-traumatic Stress Disorder individuals due to the civil war. SEA patients need encouragement, family involvement, and traditional healing to gain emotional/mental health. Interpreters can be invaluable assets if they are trained and receive supervision regularly (Suksawat and Adie, 1991). Because SEA patients have difficulty disclosing themselves, confidentiality and rights must be explained until patients feel secure and safe for self disclosure. Being polite, showing a smiling face, or often saying "I am O.K." are a part of cultural behavior. It does not mean that the patient is getting better.

Giving treatment only to patients may not be effective as family therapy due to the level of involvement of extended family members for SEA families. In addition, psychiatric treatment is a new concept for SEA refugee/war survivors and information about treatment is needed by family members as well as the patients. This also helps the children to improve mental health, build self-esteem, develop confidence, to feel more secure, to learn to resolve the problems, and deal with their emotions.

SEA patients/clients may take longer time in psychiatric treatment due to their unfamiliarity to such treatment, embarrassment to talk about their problems, needs to be assured that their treatment is confidential, and lack of understanding from their family members and care providers. According to the author's experiences, it takes about 8-10 sessions for the patients to be able to address all their problems. However, the patients who seek psychiatric treatment voluntarily are able to state their problems sooner than those who were sent for treatment.

Recommendations

According to the author's direct experience as a care provider, supervisor, consultant and one time a victim of traumatic experience, in giving psychiatric treatment to SEA refugees for their best benefits the care providers should consider the following:

1. Understand cultural background, patient/client's ability to accept American culture and Western treatment. Pay attention to body language that SEA refugees may use differently from Americans. Divergent cultural beliefs may lead to miscommunication and difficulties between the refugees and American health care providers (Lazulik, 1984). Care providers must inform the patient and the family that they should be honest and tell the truth about their well-being. There is no "losing face" in psychiatric treatment because of their confidentiality and rights.

Practitioners who are unfamiliar with SEA culture should seek consultation from an educated SEA practitioner or Asian practitioner who has culture very similar to SEA.

2. Provide clear, concise statements of etiology, prognosis, and information about treatment to the patient and his family members. Without family support, patients tend to drop out of the treatment or not comply with medication. In addition, children in the family are our future. They deserve appropriate care and concern from their parents or guardians. The more the patients' children can be involved, the better the patients are or vice versa.

3. The interpreter/translator should be trained to truly assist in communication, crisis intervention, psychiatric evaluation, psychotherapy and counseling. In particular, the interpreters should be aware of "Confidentially/legal matters," and respect the patient and their family rights.

4. If possible, combine Eastern belief and Western treatment to promote level of comfort. There are some Western concepts that do not exist in the Eastern culture. If the patients practice Eastern healing such as coining, cupping, pinching it does not mean that the patients are suicidal or the family members are abusive or homicidal. Yield to their diet and educate the patients and the family as to better nutrition.

5. If patients are on medication, make sure that they and the family members understand how to dispense medication and recognize side effects. Oftentimes, they are illiterate in both English and their native language. Thorough explanations after the prescriptions are filled is essential for patient and family to prevent overdose or non compliance with medication.

6. If the patient is involved with legal matters such as rape, drugs or gang issues, the practitioner must encourage the patient and family members to continue and cooperate with the authorities instead of moving out of town unless the patient does not want to pursue the case.

7. Promote patients and their family members' self-esteem by helping them network with supporting agencies such as minority linguistic organizations or agencies so that they will acquire friendship through Buddhist temples, churches, parenting skills groups or parent involvement groups. They should also learn English through English as a Second Language (ESL) class, and employment training. The aforementioned skills will help adults communicate with children in the family. In addition, adult role models are important for SEA families.

8. Home visitation, and therapy in schools should be implemented and provided for the SEA survivors and their children. Giving services in their home base or school base helps the patients/clients feel that they are integrated and not labeled as having psychiatric problems. In addition, the Department of Mental Health should allow children and teenagers with mild to moderate diagnoses to receive psychiatric treatment through various appropriate vendors.

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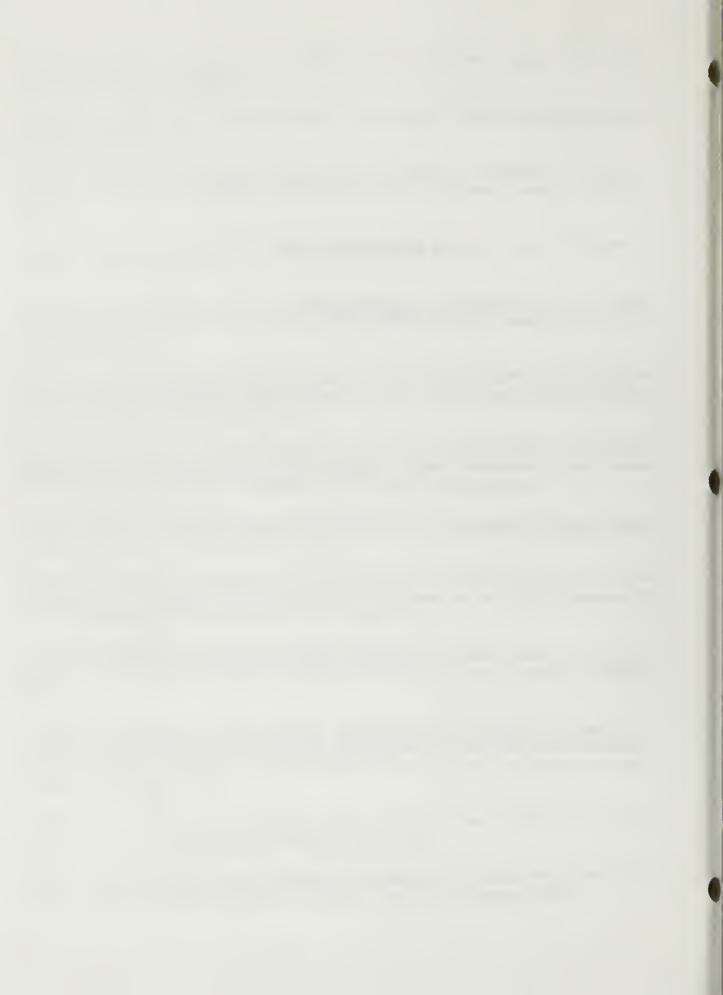
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APPENDIX A:

ABSTRACTS

ISSUES AND CONCERNS IN CROSS-CULTURAL
MENTAL HEALTH TREATMENT:
A NEED FOR RESEARCH AND APPLICATIONS

J. Abede Alexandre, Psy.D.

ABSTRACT

While most researchers and clinicians would readily accept the relationship which exists between culture and mental health, only a few, if any, would claim to be an expert in the area of cross-cultural mental health treatment. The lack of clinical applications to empirical findings in cross-cultural research may contribute on the one hand to a lack of sensitivity to cultural issues and their interaction with mental disorders and therapeutic interventions. This in turn may lead to potential abuse of the client's right to appropriate treatment and negative treatment outcome. On the other hand, it may contribute to a tendency to overgeneralize across one's culture and to make the client's cultural heritage the condition to be treated. This is disguised in the form of questions such as "How do you treat a depressed Haitian female."

There are several issues which a clinician may need to take into account when working with a cross-cultural client population. They include: Level of knowledge of psychological functioning, abilities to identify and to admit to psychological dysfunction in self and others, behavior and attitude toward mental health interventions, compliance to treatment, expectations, personal resources and community responses, tolerance of psychopathology, coping mechanisms versus resignation.

There are also several professional issues which are crucial to the clinician. They include: Sensitivity to cross-cultural issues, abilities to make a differential diagnosis without confusing cultural issues with clinical symptoms, flexibility to adjust traditional therapeutic intervention to particular cultural necessities, knowing when to refer or to diligently seek appropriate consultation.

USE OF BILINGUAL AND BICULTURAL CLINICIANS DURING THE PSYCHIATRIC/MEDICATION CONSULTATION PROCESS

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DEFINED GOALS AND OBJECTIVES:

This paper will focus on the appropriateness and usefulness of utilizing a bilingual/bicultural mental health clinician in psychiatric/medication consultations with Spanish speaking clients and psychiatrists who speak only English. In the majority of these consultations, the translation process takes place through either a client's friend or relative, who often speak limited English, or through one of the agency's bilingual support staff, who can become troubled by the information which is being conveyed. In addition, the client may be uncomfortable sharing information with these designated translators who are either too close to the situation, complete strangers, or might destabilize the client's role in the family. This paper will provide case examples that illustrate the inappropriateness of using such individuals as translators.

This paper will support the benefits of utilizing the Spanish speaking clients' bilingual clinician as the translator in the psychiatric/medication evaluations. On the most basic level, the clinician is already familiar with the case, as in most cases the psychiatric/medication consultation occurs after one to three sessions with a client. The client does not have to divulge confidential information to a third party, and thus the consultation process is not affected by the translator's reaction to the information being shared. Also, the clinician can provide to the psychiatrist new information about the client that was not included in the medical consultation referral form. The clinician can inform the psychiatrist during the consultation of culturally-appropriate or inappropriate behavior, emotions and values, which can be significant in the psychosocial/psychiatric assessment process.

By the clinician participating in the consultation, a better and more thorough understanding of the client's needs can be determined, which will lead to more effective treatment. The client also receives a more consistent and professional intervention. Based upon the benefits of this team approach, this paper will support that clinician and psychiatrist may bill separately for the session with the client.

A DIRECT SERVICE PERSPECTIVE

by Victoria Cortes-Ramirez, MSW, LCSW

OUTLINE:

1: THE DIFFERENT ETHNIC GROUPS

2: VALUES AND BELIEFS: MEDICAL, RELIGIOUS AND CULTURAL

3: ASSESSMENT

4: CLINICAL INTERVENTION

5: CASE ILLUSTRATION

1: THE DIFFERENT ETHNIC GROUPS

The Latino community is quite diversified in race, cultural beliefs, socioeconomic levels, and cognitive/educational levels.

In a pediatric hospital, the Clinical Latino Social Worker is expected to encounter patients and families from Europe, such as Spain; from South America; Central America, the Caribbean Islands, and from any Spanish speaking country; this is in addition to the Latino families living in the local area and/or out of the state. The Latino Clinical Social Worker must be knowledgeable of the cultures of each of these groups, in order to understand their ability or inability to cope with the child's illness and hospitalization.

2: VALUES AND BELIEFS: MEDICAL, RELIGIOUS, AND CULTURAL BACKGROUNDS

All these groups may have one thing in common: they speak the same language, even though there are differences in the use of some words, and accents. South Americans are quite diversified in ethnic backgrounds. For example there is European background, African Background, Indian background, and the mix of the African/European, the Indian/European, the African/Indian, etc. The Central American has a strong Indian background, while the Caribbean (Puerto Rico and Dominican Republic) has a strong African background. All these differences in ethnic backgrounds have some differences in medical beliefs as well. For example, some families have a strong belief in santeria, a holistic belief in Cuba; Curanderismo in Puerto Rico; exorcism, a Catholic practice; others, like South Americans, practice a fair amount of witchcraft to cure serious diseases, particularly mental illness. All these are forms of religious beliefs. In the more traditional way,

religion plays a big role. Most of the Latino families tend to have a very strong faith in God, and the Latino Clinical Social Worker must be able to understand the empathize with these extraordinary strong feelings, which clearly is one of the most used coping mechanisms to deal with the medical team and medical procedures.

3:      ASSESSMENT

The first thing that the Latino Clinical Social Worker would want to know about a Latino patient/family is the place of origin of the family. The reason being, is that depending where the family is from there is the possibility that the family and patient are seeing medical interventions as something very strange and may not have a strong belief in the medical/scientific method. For example, many Central Americans have a strong belief of curing diseases with natural means such as the use of certain herbs (that cannot be found here). Other families, as I already mentioned, may believe that the cure for a particular illness should be done through santeria, instead of the traditional medical model; others may use other witchcraft as means of cure. These beliefs can make the course of the medical treatment of the child very difficult for the family. As means of intervention, the Social Worker holds family meetings with hospital staff and families to educate each other, so that both sides become knowledgeable of each system.

Next, the Latino Clinical Social Worker would want to know the cognitive and educational levels of the patient and family. This is important because we can better assess the family's and child's understanding of the medical interventions and procedures being done. For example, there are families that never went to school and cannot sign their names, and most likely don't speak English. Or there are families that are highly educated and quite sophisticated, and may speak English, thus being able to understand the system better.

An important part of the child assessment is child abuse. The Latino Clinical Social Worker must be knowledgeable about the family's understanding of the difference between abuse and discipline, in order to determine what action to take. For example, the family could be well aware that the child is not to be punished by putting him/her against a hot radiator, and that that constitutes abuse. Or it could be a case of a newly arrived family to the USA and in the process of getting to know the system, a child accidentally got burned while reaching something from the stove (family may not have a stove in the native land).

4:      CLINICAL INTERVENTION

During the course of a child's hospitalization, patients and families go through a difficult period of stress, anxiety and adjustment. With Latino families who do not speak English, these stressors are compounded and complicated by the lack of communication with hospital staff. Many of the children and families come from a foreign country, and in addition to the lack of language, they find themselves in a culture shock, adding to the already existing medical trauma and fear.

When the patient is an older child (adolescent or latency age) the Latino Clinical Social Worker works closely with the patient supporting him/her and understanding his/her need for expression of anger, pain, anguish, and frustration. These emotional needs must be met by the parents as well, enabling them to better cope with the hospitalization and illness of the child.

Another intervention of the Clinical Social Worker in a pediatric medical setting is child protection. The Latino Clinical Social Worker must be able to address this issue with the parents/guardians in a non-threatening, supportive manner. In many cases parents need to be educated about the system and how to discipline the children.

In some cases, families may be referred to DSS (try to avoid statements such as "filing a 51-A" with the parents, they may not understand what that means or may become terrified and paranoid, thus adding more stress to the family) for investigation. In some cases what the family needs is education about the American system, and new parenting style or skills. If the social worker has skills in parenting he/she may be able to continue helping the family; otherwise, the family will be referred to the appropriate agency or clinic, or group for follow-up.

In most cases, regardless of whether the family resides locally or abroad, the greatest need in the family and the patient, is emotional support. The Latino Clinical Social Worker in a pediatric setting works very closely with these families providing emotional support, coordinating services, educating families in the new system (hospital community and community as a whole), and advocating for children. The need for emotional support is greater particularly when the family has no relatives or friends locally. Besides the emotional support from the Latino Social Worker, in order to best help the children and families to cope with the stress of the child's illness and hospitalization, the Latino Social Worker attempts to involve other family members or friends; other supportive systems, such as Spanish speaking volunteers, people from the church, consulates, other Latino families in the hospital, the Spanish media and other community members may respond as well.

5:    CASE ILLUSTRATION

C is a 7 year-old girl from South America with Amegakaryocytic Thromboccytopenia (AMT), a rare disease (only 5 children in the world have it), in which the bone marrow fails to produce platelets, and for which there is no medication/drug, as yet.

C and her mother came for the first time to the USA seeking some type of medical treatment. They didn't know the language, the customs, or the medical system. C came straight to the inpatient unit from the airport. To all the hospital staff, C was one more patient, but to C and her mother this was a shocking world.

When the Latino Clinical Social Worker came to meet with them in the unit, both C and her mother began to cry in an emotional relief. Mother's statement was: "I am so lost, but God must be with us because now I will be able to talk to you about my terrible fear".

The Social Worker began to provide emotional support to both, C and her mother, while educating mother about the American hospital system by comparing her previous hospital experience with the current one. Both C and her mother felt alone in the new country, missing the family, co-workers and friends. They needed to be connected with their dear ones, and start a new support system here.

Eventually, C became an outpatient on a weekly basis, when the Social Worker would meet with her and the mother, for continuation of emotional support, and for coordination and arrangements for their return to their homeland.

Once they were back in their homeland, complications arose because of the difficulties with shipments of the experimental drug. The Latino Social Worker worked with Consulate, Immigration, and the family via telephone so that the child could either return to the States, or could have the medication in the homeland.

Child and entire family are now residing in another part of the States where child is undergoing preparation for a Bone Marrow Transplant, but the Latino Social Worker here continues to work with the Social Worker from where the child is hospitalized, organizing fund raising to cover the cost of the transplant.

CHILDREN'S MUSEUM WORKSHOP

Bhavini Joshi, MSW

Background:

Urban cities and its communities are faced with the growing problem of homelessness, the nature of which has changed dramatically from the historic view of a group of single adults to include that of families with children. Homeless families are the fastest growing segment of the homeless population in the United States.

Every night, according to the National Academy of Sciences (1988), approximately 100,000 American children go to sleep homeless. The reasons for family homelessness are varied -- poverty, shortage of affordable housing, battering/abuse, unemployment, evictions, fires, drug abuse, family dysfunction, lack of adequate supports, violence, etc.

Once homeless, the family faces a myriad of consequences which can put them under severe stress and if this stress is not addressed it could lead to further problems, psychiatric or dysfunctional in nature. Because of the very nature of the homeless family being in constant transition and the primary focus for the family being to acquire housing and maintain the daily living situation, stress and mental health issues are put on the back burner. Therefore, these issues are only addressed in a crisis situation or if the family member is unable to function day to day.

Traditional methods of mental health intervention, in this case most likely outpatient services, do not always meet the families' needs. In my experience, most likely there are transportation and day care problems, there's the stigma of going to a mental health provider, the issue of spending time in therapy versus looking for housing and most of all the limited availability and accessibility of outpatient services or family therapy.

In light of the above issues, it was important to provide mental health intervention via non-traditional methods to address the general needs of a very diverse, multicultural and transitional population as well as educate the caregivers regarding the same.

I approached the Children's Museum in order to see if they would be interested in supporting collaborative program development to address the need for non-traditional mental health intervention. They were very receptive and shared their concern for the problem and thereby, we jointly developed workshops which addressed a broad variety of mental health issues via activity, to be conducted at the museum by myself and the early childhood staff.

Philosophy and Goals:

The overall goals of the workshop are to address varied mental health issues of concern, as seen by the families and staff, via a broad range of activities. It is to enable them to come to a community based institution and a conducive, friendly, stimulating environment -- focused upon the issues of concern.

Workshop Objectives:

- Increase the participants' knowledge around mental health issues

- Address issues of concern

- Develop linkage and networks between families and care givers for support

- Increase the participants' ability to access services in the mental health system if need be

- Improve group and interpersonal skills

- All for free exploration and stimulation by open access to the Museum

THE HAITIAN MENTAL HEALTH CLINIC

Michele Cuvilly Klopner, Psy.D., Director
Loretta Saint-Louis, Ph.D., Clinical Anthropologist

ABSTRACT

The Haitian Mental Health Clinic is an outpatient program which provides psychodiagnostic, individual and family psychotherapy services to Haitian immigrants. The Clinic seeks to overcome traditional barriers to mental health service utilization through the provision of culturally relevant care. In recognition of the multiply-determined difficulties of Haitian immigrants, it also attempts to provide integrated, comprehensive care, and as such engages in both advocacy and the delivery of social services.

The Clinic also provides home based visits to the HIV infected and AIDS patients in the area.

The presenters will provide an overview of their work with the Haitian community, as well as discuss the clinical challenges which they confront in providing services to that population.

DEVELOPMENT OF HOUSING AND CLINICAL SUPPORT SERVICES FOR ASIAN-AMERICANS DIAGNOSED WITH SEVERE MENTAL ILLNESS

May Kwan Lorenzo, Consultant
Paul TonThat, Program Director
Lyon St.Residence, Bay Cove Human Services, Inc.

Comprehensive Summary

Asian-Americans with severe mental illness often face barriers in accessing mental health services. This paper will describe the development of Lyon St., a residential program in Boston, specifically designed to meet the unique cultural and language needs of this population.

Objectives

To present an overview of the program's design and development. Areas include:

- understanding the concepts of mental illness within Asian cultures

- the role of the advisory committee

- recruitment and training of bilingual and bicultural staff

- integration within the mental health system.

- description of the collaboration between the Department of Mental Health, HUD, BHA and BCHS.

Therapeutic Suggestions

The integration of culturally and linguistically appropriate services is crucial to meeting the mental health needs of the Asian population.

KINSHIP PROVIDER FAMILIES OF COLOR

Sabrina Manigo-Glover, ABCD

ABSTRACT

Kinship Provider Family data is clearly an unmet data need that could permit more effective advocacy on behalf of children, youth and adults of color. The data will not only help to promote intergenerational concerns in family/mental health policy but also allow the kinship providers to be potential resources in decision making regarding the needs of children and families of color.

SUMMARY

Currently, more kinship providers of color including grandparents are assuming guardianship of children due to various crises. Some children are being raised by other family members, due to parents' substance abuse/addiction, physical abuse or any other disability they may have as well as economic stress/poverty.

The increasing rate of kinship provider families has become so apparent that it has received national attention. Since 1987, Grandparents as Parents Support Groups (GAPs) across the country have emerged to assist grandparents and other kinship providers raising their children's children. However, there are no GAPs or coalitions of this kind in Boston. Who is advocating for these families?

Kinship providers are having to step in to compensate for parenting and child rearing. What are kinship providers having to give up so the children "at-risk" will hopefully, not be shifted into foster care placement or institutionalized care? Currently, there is an increasing number of children under 18 years old in placement. The fastest growing age group in placement has been children under 6 years old.

Clearly, there is a need to identify kinship providers, obtain knowledge about what their issues are; to begin tracking qualitative as well as quantitative data and outreach to more kinship families in communities of color. The goal is to strengthen the kinship provider family of color as well as maintain a keen interest of the child "at-risk", to further enhance development and growth. Objectives are to improve the kinship providers' adjustment to being parents once again and to increase access to resources and services which can provide real care in keeping these families intact.

ANALYTICAL FRAMEWORK FOR QUALITY MANAGED CARE OF STATE-PURCHASED MENTAL HEALTH SERVICES

Arthur L. Mathis, Ph.D.

Department of Mental Health
Metro Boston Area
Department of Quality Management

In the ongoing effort to privatize publicly supplied services, the Department of Mental Health has begun the process of structurally reorganizing its mental health care system. The Department is in the process of being changed from a provider (supplier) of mental health care to a purchaser (customer) of mental health care. The responsibilities of the Department as supplier becomes the mandate for securing necessary, acceptable, and appropriate services in the marketplace for qualified beneficiaries (clients). An analytical framework for the management of quality from the consumer's perspective is presented with emphases on the verification of quality and cost.

THE DELIVERY OF MENTAL HEALTH SERVICES TO PERSONS OF COLOR

John R. Moore, ACSW, LICSW
Social Worker, Comprehensive Child Health Program

Title of Workshop:

Diversity for the 21st Century

Abstract

The Diversity Workshop will be thought provoking; creating an atmosphere of discussion, as well as a brief look into the past, present and future of Race Relations. Most of all, the goal is for participants to become aware of cultural and ethnic diversity which is vital at all levels of the Health Care, Human Service and Mental Health systems; and that differences enhance these systems and the service to the ever so diverse population, whether we are practicing in a clinical setting, education, research, policy or administration.

Summary

The Workshop should provide to teachers, managers and providers of various disciplines who plan for or service diverse cultural and ethnic backgrounds and populations.

Goals and Objectives

- Begin to understand one's own attitude and behavior about cultural and ethnic differences

- Deal more comfortably and effectively with peers and subordinates

- Identify where you/your workplace are or should be in the process of cultural and ethnic competence

- Utilize individual differences within groups for more creative problem solving

Understanding the Impact of War Trauma and the Refugee Camp

Experience on Cambodian Refugee Adolescents Residing in Site Two

Linda Son, M.Ed.

Summary

The proposed paper examines the impact of war trauma and long stays in refugee camps on 182 Cambodian refugee adolescents between the ages of twelve and thirteen. These adolescents are survivors of the Pol Pot regime, also known as the Asian Holocaust and residents of the Site Two refugee camp, located in Thailand. Their war trauma experiences comprise a range of calamities including separation from family, lack of food, shelter, and medicine, loss of family members, witnessing the torture or murder of family members and others and forced labor.

The objectives of the proposed paper are the following: (1) identify psychological and behavior problems prevalent in this population; (2) correlate severity of trauma experiences with psychological and behavior problems; (3) compare the results of this study with other studies which have examined the impact of war trauma on children; and (4) discuss treatment implications for practitioners treating this particular population. Study findings are based on Achenbach Youth Self Report (YSR), a structured self report instrument which measures physical, psychological, and social functioning. The YSR was chosen because of its wide acceptance as a valid cross-cultural instrument.

EFACHAM
Evaluation Family Counseling, Haitians and Minorities, Inc.

Primrose R. Tavares, Ed.M.
Administrator

I.   PHILOSOPHY:

EFACHAM was created in 1987 to answer the critical mental and emotional needs of Haitians and Minorities who are recent immigrants in the Boston area. These needs are best summarized by the words of EFACHAM's Executive Director, Mrs. Tavares: "Haitians must face class, age, race, handicap and language discrimination in a dangerous combination." EFACHAM recognizes that often the culture shock of moving to another country may precipitate or complicate a fragile mental condition. Often the stress of adjustment and other new dimensions may even create new emotional needs, not formerly present in the country of origin.

EFACHAM uses an approach of first understanding one's culture and language, in order to develop positive relationships with clients and their families. It is EFACHAM's belief that cross-cultural specialization is an essential requirement for all its staff. In order to meet the needs of a diverse and unique population, the staff must be able to understand the culture and language of the people they seek to help.

EFACHAM's Executive Director and founder is a specialist in the mental health field for over twenty years. She believes and promotes that: "Regardless of the condition of a mentally disturbed person, there is always some intrinsic value and some hope, and it remains a space in the patient's soul where the therapist can explore in a positive manner.... It is when the therapist fully understands the patient, his milieu and his values that a realistic and viable evaluation and treatment can re-establish equilibrium in an affected person's life".

II.   OBJECTIVES:

The goals of the program are multi-fold in the results it can bring. Families, individuals, the City of Boston as well a the Commonwealth of Massachusetts, all can benefit from EFACHAM's unique and most comprehensive approach.

The agency's primary objective is to have established itself as a model of sensitive, community-oriented, non-stigmatized mental health service for Haitians and Minorities, a population segment of recent immigrants who tend to be traditionally reluctant to seek mental health care.

EFACHAM uses a multidisciplinary staff who have affinity with the clientele to whom it provides special services in an appropriate cultural setting, to achieve the following:

1. Improved access and fairness for mental health evaluation and treatment to a disadvantaged population segment, through increased sharing of pertinent information between client and the clinician.

2. Better adjustment of the mentally disturbed person in his community, after psychiatric hospitalization.

3. Contributed cost saving for MEDICAID Program, by preventing unnecessary repeated high costly hospitalizations.

4. Reduced high risk crisis in the community through early intervention.

5. Increased self-esteem through delivery of services in appropriate cultural setting, resulting in prompt recovery.